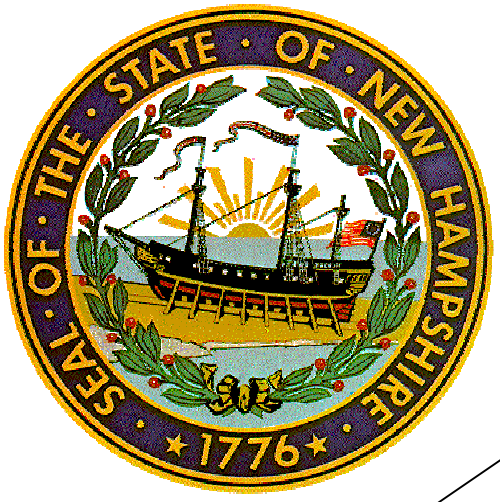


# Quality Strategy
# for the
# New Hampshire Medicaid
# Care Management Program

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**NH DHHS welcomes your comments on this draft until Aug 17, 2012 at:**

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**Last Updated: July 16, 2012**

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## I. Introduction

### A. General Information

The 2011 New Hampshire (NH) State Legislature directed the Commissioner of the Department of Health and Human Services (DHHS, the Department) to develop a comprehensive statewide managed care program for all Medicaid program enrollees. (Public Health, Chapter 126-A, NH MCO Contract Section XIX) The goals of the newly established Medicaid Care Management program are to offer "the best value, quality assurance, and efficiency, maximizing the potential for savings, and presenting the most innovative approach" to the provision of health services for the State's Medicaid recipients.

The Care Management program will be rolled out in three phases. Step One of the Care Management program will include all State Plan Amendment services, except long term care services, for all NH Medicaid recipients (mandatory for those populations that do not require a waiver for mandatory enrollment). With Center for Medicare and Medicaid Servcies (CMS) approval, Step Two will begin mandatory enrollment for all populations and will incorporate, both non-waiver and waiver long term care services into the Care Management program. Step Three allows for the enrollment of any New Hampshire Medicaid expansion populations that could resulting from State's implementation of the Affordable Care Act, and completes the State's strategy for a comprehensive statewide program inclusive of all NH Medicaid populations and all Medicaid services (Appendix A). Under state statute, dental services will remain fee-for-service. NH Medicaid recipients who are also part of the VA health system and those spending down to meet Medicaid requirements are excluded from the Care Management program.

To date, the State has had a disaggregated approach to quality oversight driven primarily by the regulatory requirements of various DHHS programs. With the new Care Management program, DHHS has the opportunity to develop a comprehensive NH Medicaid Quality Strategy, building upon the legislative goals of value and efficiency, and focused on improving the health of Medicaid recipients. The State's initial quality improvement objectives will be drawn from generally understood opportunities for improvement. After the Care Management program has been established, the Department will perform regular monitoring and analysis to identify the program's successes and new opportunities for improvement and amend the Quality Strategy to include additional population-based quality improvement activities. It is also the Department's intention to, over time, harmonize the NH Medicaid Quality Strategy with the National Quality Strategy, synergistically using State's resources to champion national campaigns and capitalize on grant and other federal initiatives.

The Quality Strategy will serve to assure stakeholders that the State's managed care organizations (MCOs) are in contract compliance and have committed adequate resources to perform internal monitoring and ongoing quality improvement and actively contribute to health care improvement for the State's most vulnerable citizens.

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**B. Managed Care Quality Program Objectives**

The State's initial quality improvement objectives will be drawn from generally understood NH Medicaid opportunities for improvement and will include four Quality Incentive Projects (QIP) of the State's choosing and four Performance Improvement Projects (PIP) of the MCOs choosing, subject to DHHS approval. Other activities will include: comprehensive, routine, population-based measurement and monitoring; health plan operations and contract compliance reporting; and annual surveys of member satisfaction with health plans and Medicaid providers. After the Care Management program has been established, the Department will draw from these and other activities to identify additional Medicaid program priorities, strengths and opportunities, and will establish additional program goals. The Department will also incorporate recommendations from the public, MCOs and the EQRO Technical Report in setting new goals and revising the Quality Strategy.

In complement to the State's Quality Strategy, each MCO shall develop, maintain and operate a Quality Assessment and Performance Improvement (QAPI) program, as required by the Code of Federal Regulations, 42 CFR 438.240, and the NH Medicaid Care Management Contract. The QAPI is subject to the approval by the State. Each MCO's QAPI will describe the four MCO performance improvement projects (PIP), at least one of which must have a behavioral health focus. After the MCOs have had the opportunity to make initial assessments of their membership and, in consultation with their consumer and provider advisory boards, determined the greatest potential health care quality improvement opportunities, the State will begin quarterly Quality Improvement meetings with the three MCO Medical and Quality Improvement Directors. These meetings will routinely bring all of the MCOs together, take an agnostic perspective on NH Medicaid program, and, to the greatest degree possible, harmonize the PIPs and other quality initiatives across the three MCOs and the NH Medicaid program.

In addition to the four annual MCO performance improvement projects, DHHS will annually select four quality improvement initiatives for its Quality Incentive Program (QIP). For each of the initiatives selected, the MCO will be eligible to receive up to one-quarter of the one percent (0.25%) of QIP premium withhold for successfully meeting or exceeding the improvement target. These quality incentive initiatives may change each contract year and will reflect both NH Medicaid priorities and achievable targets for the MCOs. For the Quality Year 1 (January 1, 2013-December 31, 2013) the following QIP initiatives have been selected (Appendix B):

- Increasing Adolescent Well Care Visits, a Healthcare Effectiveness Data and Information Set (HEDIS) measure,
- Reducing 30 day and 180 day Readmissions to New Hampshire Hospital, New Hampshire's state run inpatient psychiatric facility, a Substance Abuse and Mental Health Services Administration (SAMHSA) measure,
- Improvement in Getting Needed Care, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure,
- Improving Maternal Smoking Cessation, a DHHS measure.

MCO QAPI programs will include performance measurement for the above initiatives as well as DHHS required Quality Indicators (Appendix C and D) and routine reporting on health plan operations (Appendix G). All performance data will be submitted to the State. The State will conduct an initial CAHPS survey to serve as a baseline of standardized information on enrollees'

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experiences with the NH Medicaid program. Each MCO will then annually conduct a comprehensive CAHPS survey (NH Medicaid Care Management Contract Section 15.7.3 and 20.5.2) to continue to assess member satisfaction with the health plans and services. The results of these assessments will be shared with the Department and posted on the State's NH Medicaid Quality Indicators website.

## II. Assessment

As required by 42 CFR 438.202(d), the State will assesses how well the Care Management program is meeting the objectives outlined in the Introduction through analysis of the quality and appropriateness of care and services delivered to enrollees, the level of contract compliance of MCOs and by monitoring MCO activities through the use of health information technology on an on-going basis.

### A. Quality and Appropriateness of Care and Services

New Hampshire assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through:

- NH Medicaid Quality Indicators monitoring (on the NH Medicaid Quality Indicators website, http://nhmedicaidquality.org and Appendix C and D), including the CMS Pediatric and Adult Quality Measures,
- PIP and QIP projects,
- NH Medicaid Care Management Contract Compliance, Operations and Quality Reporting,
- NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems Population-based, special and ad hoc analysis and reporting,
- MCO National Committee for Quality Assurance (NCQA) accreditation review, and
- External Quality Review Organization (EQRO) Reports, including NH Medicaid population analysis and the EQRO Technical Report.

*NH Medicaid Quality Indicators*

The NH Medicaid Quality Indicators is a new initiative for the NH Medicaid program, aimed at aggregating population-based measures to enhance the identification of program strengths and opportunities and make this data publicly available on the NH Medicaid Health Indicator website. The measures are a selection of standardized and validated measures from recognized and credible organizations including the Center for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), the Healthcare Effectiveness Data and Information Set (HEDIS), Center for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), among others. The current measure set includes all of the CMS Adult and Pediatric Quality Indicators that NH Medicaid collects data to report. It is intent of DHHS to have this measure set grow to include additional measures on physical health, behavioral health, lifestyle measures, and Medicaid services and supports. With Step Two, the addition of the waiver populations and services, further measures related to home and community-based services will be added. The website will also include the HEDIS and CAHPS measures for each of the NH Medicaid Care Management programs. To ensure the integrity, reliability, and validity of the MCO encounter data, the State will contract with an EQRO to

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audit and validate encounter data and to provide technical assistance to MCOs in collecting and submitting the requested information. The NH Medicaid Quality Indicators website will be updated whenever new data becomes available but no less than annually; measures derived from MCO encounter data will be updated quarterly.

*Performance Improvement Projects and Quality Incentive Program Initiatives*
Each MCO shall develop and implement four MCO performance improvement projects (PIP), subject to the approval of the State, at least one of which must have a behavioral health focus. After each MCO has had the opportunity to make an initial assessment of its membership, and in consultation with their consumer and provider advisory boards, determined the greatest potential for health care quality improvement opportunities, the State will begin quarterly Quality Assurance and Improvement meetings with the three MCO Medical and Quality Improvement Directors. These meetings will routinely bring all of the MCOs together, take an agnostic perspective on NH Medicaid program, and, to the greatest degree possible, harmonize the PIPs and other quality initiatives across the three MCOs and the NH Medicaid program.

Additionally, DHHS will annually select four quality improvement initiatives for its NH Medicaid Quality Incentive Program (QIP). For each of the initiatives selected, the MCO will be eligible to receive up to one-quarter of the one percent (0.25%) of QIP premium withhold for successfully meeting or exceeding a improvement target. These quality incentive initiatives may change each contract year and will reflect both NH Medicaid priorities and achievable targets for the MCOs. For the Agreement Years 1 and 2 (January 1, 2013-December 31, 2013) the following QIP initiatives have been selected (Appendix B):

- Increasing Adolescent Well Care Visits,
- Reducing 30 day and 180 day Readmissions to New Hampshire Hospital, New Hampshire's state run inpatient psychiatric facility,
- Improvement in Getting Needed Care, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure,
- Improving Maternal Smoking Cessation.

*MCO Contract Compliance, Operations and Quality Reporting*
The NH Medicaid Care Management Program includes a robust list of Required Quality Reporting Measures (Appendix G) and a comprehensive list of encounter data elements (Appendix E). These data will be presented both as individual measures and aggregated into measure sets to demonstrate the impact of specific programs and overall MCO program impact. MCO encounter data will be validated by the State's EQRO; pharmacy data will be validated by the State's pharmacy benefit administrator.

*NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data System Reporting*
NH DHHS Office of Medicaid Business, Policy Bureau of Healthcare Analytics and Data Systems has oversight of data, analysis and reporting. The Bureau currently functions to create ad hoc reports as requested or needed to ensure the delivery of quality care, the development of sound policy and for financial oversight of the Medicaid program. The Bureau will continue to support DHHS reporting on the NH Care Management program. The Bureau will be responsible

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for oversight of the maintenance and aggregation of MCO data into a single database, which will be accomplished inside the Medicaid Mangagement Information System (MMIS) Reporting Repository. The Bureau will also provide population-wide, DHHS-wide, special and ad hoc analysis and reporting from the repository. The Bureau will be the primary DHHS contact for online web access to applications and data to access, analyze, or utilize data captured in the MCO systems and to perform reporting and operational activities. (Section 22.5.4.3) The Bureau will assist the EQRO in their oversight of MCO functions and in the creation of statewide, population-based reports on the Care Management program.

The NH Medicaid Quality Indicators website is housed within the Bureau. The Bureau is also home for NH's "all payers claims database," the NH Comprehensive Health Care Information System (CHIS). CHIS was created by NH state statute to make health care data "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices."[1] The same legislation that created the CHIS also enacted statutes that mandated that health insurance carriers, including the new Medicaid MCOs, submit their encrypted health care claims data, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to the state. Access to this database allows for robust Medicaid reporting and private sector benchmarking.

*MCO NCQA Accreditation Review*

The NH DHHS required that the contracting MCOs obtain and maintain NCQA accreditation. Additionally, each MCO will conduct an annual HEDIS and CAHPS surveys. The maintenance of accreditation activities and the results of the annual HEDIS and CAHPS will be reviewed, shared, and posted on the NH Medicaid Quality Indicators website. The MCOs Annual Report and QAPI reporting will also address activities related to maintenance of NCQA accreditation, identify MCO program strengths and impact, and articulate how opportunities for improvement will be addressed in the upcoming year. The MCO Annual Report and QAPI Report will be posted to the DHHS Medicaid Care Management website.[2]

*External Quality Review Organization Activities*

The NH DHHS will contract with an external quality review organization, to be procured in the Fall/Winter 2012 as required by 42 CFR 438 Subpart E. To comply with Federal regulations, 42 CFR 438.358(b), the federally mandatory EQRO scope of work for the NH Medicaid EQRO will include:

- Validation of Performance Improvement Projects and Quality Incentive Projects,
- Validation of MCO quality performance measures (Appendix C and D),
- Validation of NH Medicaid Care Management Quality Strategy, and
- Preparation of an EQRO Technical Report for each Medicaid managed care plan.

Optional federal EQRO activities required in the NH Medicaid EQRO scope of work will include:

[1] NH CHIS Welcome website. Accessed at: http://www.nhchis.org/ on July 3, 2012.
[2] NH DHHS Care Management website. Accessed at: http://www.dhhs.nh.gov/ocom/care-management.htm on July 3, 2012.

- Validation of MCO encounter data submissions,
- Validation of MCO consumer and provider surveys, and
- Calculation of NH Medicaid aggregate performance measures in addition to those reported by the MCOs,

Optional federal EQRO activities for the NH Medicaid EQRO may also included:

- Performance improvement projects in addition to those conducted by the MCOs, (i.e.: conduction of focused studies of health service delivery issues such as coordination, continuity, access and availability of needed services).

NH DHHS will provide data files to the EQRO for each of the MCOs. As part of its annual reporting, the State's EQRO will prepare a Technical Report as a compendium of each MCO's plan-specific activities, services and operations adherent to the CMS protocols found in 42 CFR 438.364 for external review quality reports. Specifically the EQRO Technical Report will include:

- An overview of MCO activities, including,
  - A description of the manner in which MCO data was aggregated and analyzed, and
  - The conclusions drawn from the data on the quality, timeliness, and access to care provided by the MCO.
  - For each MCO activity reviewed, the EQRO will address:
    - The objective of the MCO activity and the objective of the EQRO oversight function,
    - The technical methods of data collection and analysis,
    - A description of the data obtained, and
    - The conclusions drawn from the data;
- An assessment of each MCOs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients,
- Recommendations for improving the quality of health care services furnished by each MCO,
- Comparative information across the State's three MCO programs,
- Population-based aggregate measurement and analysis, and
- An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This EQRO activity will commence after the first year of NH Medicaid Care Management program operations.

Each EQRO Technical Report will also include information on trends in health plan enrollment, provider network characteristics, complaints and grievances, identification of special needs populations, trends in utilization, statements of deficiencies and other on-site survey findings, and financial data, in addition to the scope of work outlined above on projects, performance measures, the quality of the encounter data, and any requested EQRO measures or focused clinical study findings. The EQRO will then compile an executive summary of each MCO, including a summary of each plans strengths and weaknesses. The executive summary and full

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report will be made available on the New Hampshire Department of Health and Human Services Medicaid Care Management public website.

The Department will use the annual Technical Report to apply sanctions or take other corrective action as designated in the NH Medicaid Care Management Contract, to evaluate existing program goals and inform new program goal development. The Department will also use the Technical Report to inform any needed contract amendments or revisions.

*Data on Race, Ethnicity and Primary Language*
The State currently obtains race (multiple categories), Hispanic ethnicity, and primary language spoken, during its eligibility and NH Medicaid enrollment process. This information will be shared with the MCOs as a part of daily eligibility data feeds.

Data on race, ethnicity and primary language, as well as other demographic and health status information, will be captured more robustly during each MCO's enrollment process via the MCO enrollment form and the new enrollee health risk assessment. The implementation of the State's new MMIS program will allow the State to collect additional information on race, ethnicity and primary language.

*NH Medicaid Care Management Clinical Standards and Guidelines*
The Department has taken four complementary approaches to establishing high clinical standards and guidelines:

- Compliance with specific federal regulation for Medicaid MCO clinical standards and guidelines,
- Compliance with federal agency and national organizations recommendations and guidelines,
- DHHS review and approval of all MCO standards and guidelines, and
- Comprehensive compliance with federal and state regulatory standards and guidelines.

Consistent with 42 CFR 438.204(g), the NH Medicaid Care Management program has adopted clinical standards and guidelines for access to care, structure and operations, and quality measurement and improvement at least as stringent as in 42 CFR 438 Subpart D. Compliance with these specific standards and guidelines can be found throughout the NH Medicaid Care Management Contract and are catalogued in Appendix F.

The State has built upon the credibility and strength of several federal agencies and national organizations in adopting guidelines for care management. NH Medicaid Care Management Contract Section 10.2.3 of the contract refers MCOs to the Agency for Healthcare Research and Quality guidelines for the development of Patient Centered Medical Homes. NH Medicaid Care Management Contract Section 10.2.4 requires that MCO participate in the development and support of Health Homes as defined by the Center for Medicare and Medicaid Services. MCO wellness and prevention programs must comport with the American Academy of Pediatrics Bright Futures program recommendations and with all United States Prevention Services Task Force A and B rated prevention and primary services for children and adults.

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Section 20.2 of the NH Medicaid Care Management Contract requires the MCOs to adopt evidence-based practice guidelines built upon high quality data and strong evidence. In addition to their standard practice guidelines, MCOs are required to develop additional guidelines to meet the health needs and other opportunities for improvement identified in their Quality Assessment and Performance Improvement programs. All MCO practice guidelines will be subject to DHHS approval prior to the onset of the Care Management program and annually thereafter (NH Medicaid Care Management Contract Section 21.1.3). All practice guidelines will be available on the MCO websites, and to providers, members and potential members upon request. MCO practice guidelines will be used to inform their coverage decisions, utilization management and member educational activities.

Finally, Section 26 of the NH Medicaid Care Management Contract requires the MCOs, their subcontractors, and their providers to be comprehensively compliance with all applicable federal and state regulation, both present and future. Specific NH Medicaid Care Management Contract Sections also cross reference and require compliance with specific corresponding federal or state regulation as appropriate for that Care Management program element.

**B. Level of Contract Compliance and How New Hampshire Medicaid Determines Compliance**

As required by 42 CFR 438.204(g), the State has established standards in the Care Management Contract regarding access to care, structure and operations, and quality measurement and improvement. Appendix F outlines each required component of the federal regulations and identifies the section of the NH Medicaid Care Management Contract where this requirement is addressed. In addition to the federal regulatory standards, the NH Medicaid Care Management standards are present throughout the contract and as discussed in the section above.

The State will ensure MCO contract compliance in requiring MCO self-regulation and through direct DHHS oversight. NH Medicaid Care Management Contract Section 6.1.1.13 obligates each MCO to have a Compliance Officer whose primary responsibility is the assurance of the program's contractual and regulatory compliance.

Direct DHHS oversight of MCO contract compliance will be the primary responsibility of the NH Medicaid Director of MCO Operations and the three NH Medicaid Care Management Account Management Teams, one team for each of the MCOs. The Account Managers will act as a liaison between DHHS and the MCO staff on all issues of MCO monitoring. Under the guidance of the Director of MCO Operations, the NH Medicaid Care Management Account Managers will work collaboratively with the cross functioning Care Management Quality team and various cross functioning program subject matter experts.

As discussed in the Quality Strategy "Part II. Assessment, A. Quality and Appropriateness of Care and Services," MCO contract compliance and the equally importantly impact of contract compliance on members, will be monitored by the following activities:

- NH Medicaid Quality Indicators reports, including the CMS Pediatric and Adult Quality Measures,
- MCO PIP and QIP projects,
- MCO Contract Compliance, Operations and Quality Reporting (Appendix G),

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- NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems population-wide, DHHS wide, special, other and ad hoc analysis and reports,
- MCO NCQA accreditation review, and
- External Quality Review Organization (EQRO) Reports, including the EQRO Technical Report and NH Medicaid population wide, aggregated reports

**C. The Role of Health Information Technology**

New Hampshire assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through the collection and analyses of data from many sources including: New Heights - the State's eligibility database, the Medicaid encounter and provider data, initially stored in the NH DHHS Data Warehouse, and with the completion of the State's new MMIS, in the MMIS Reporting Repository; the National Committee on Quality Assurance (NCQA), the Healthcare Effectiveness Data and Information Set (HEDIS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS); and other data accessible to NH Medicaid, such as the Comprehensive Healthcare Information System database (all payer claims database, managed by NH DHHS). DHHS will have online web access to MCO applications and data to access, analyze, or utilize data captured in the MCO systems and to perform reporting and operational activities. Other sources of data may include findings from the External Quality Review Organization's Technical Report and the NH Division of Public Health Services implementation of CDC's Behavioral Risk Factor Surveillance System (BRFSS), among others.

The MCOs are required to have information systems capable of collecting, analyzing and submitting the required data and reports. The State's EQRO and pharmacy benefit administrator will ensure the accuracy and validity of the MCO data submitted.

The State's primary HIT challenge is currently data storage and exchange, related to the implementation of a new Medicaid Medical Information System (MMIS). After the State has completed its transition to the new MMIS system, all MCO encounter data, along with DHHS eligibility data and remaining fee-for-service data, will be stored in a single database, the MMIS Report Repository. Until such time, encounter data will be housed in the DHHS Data Warehouse.

Both Medicaid fee for service and MCO encounter data history will be provided to MCOs on a regular basis for their enrolled members. Enrolled provider data and active service authorization data will also be shared. Once the new MMIS system implementation is complete, these interfaces will be fully automated. Prior to that time more manual processes will be employed.

While MCOs are not eligible for incentives under the Health Information Technology for Economic and Clinical Health (HITECH) Electronic Health Record (EHR) incentive program, they will benefit from an increase in the meaningful use of EHRs that the HITECH program promotes. In 2012, the New Hampshire Health Information Organization is expected to begin deployment of a statewide Health Information Exchange (HIE) that would greatly increase capacity of provider-to-provider transmission of health information.

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## III. Improvement

### A. Assessment Based Activities

The State of New Hampshire will initially work to improve the quality of care delivered through the utilization of incentives and disincentives including:

- Contract Activities, including:
  - Quality Incentive Program with Financial Incentives,
  - Performance Improvement Projects,
  - Payment Reform Incentive Plan, and
  - MCO sanctions.
- Convening Cross-MCO Quality Activities, and
- EQRO Technical Review and Report.

*Contract Incentives, Project, Plans and Sanctions*

For each of the NH Medicaid Care Management Contract years, DHHS will select four Quality Incentive Program (QIP) initiatives (Appendix B). Each MCO will have 1% of the aggregate PMPM withheld to support the QIP. This withhold will be repaid, either in part or in full, when the MCO performance measure makes significant progress toward and/or meets the improvement goal. Additional financial penalties will be levied for reductions from measure baselines. The first program year QIP initiatives are:

- Increasing Adolescent Well Care Visits: Using the HEDIS measure for adolescent well care visits, the MCO will receive 0.125% of the withhold for exceeding 50% of adolescents with well care visits, and additional 0.125% for exceeding 55% and a penalty of 0.25% for a measure below 40%.
- Reducing 30 day and 180 day Readmissions to New Hampshire Hospital: The MCO will receive 0.0625% of the withhold for a 10-20% decline and 0.125% for greater than a 20% decline for improvement in the 30 day or 180 day readmission rate; and a penalty of 0.125% should the readmission rate rise greater than 20% from the baseline.
- Getting Needed Care: The most recent year available will serve as the baseline from the NCQA Quality Compass for Medicaid Managed Care Organizations for the CAHPS measure on Getting Needed Care Composite. CAHPS measure will be weighted for the proportion of children and adults in each MCO. The MCO will receive 0.125% of the PMPM withhold for exceeding the 50$^{th}$ percentile and an additional 0.125% for exceeding the 75$^{th}$ percentile; a penalty of 0.25% will be assessed for falling below the 50$^{th}$ percentile.
- Improving Maternal Smoking Cessation: The MCO will receive 0.125% of the withhold for a smoking cessation rate of greater than 26% and an additional 0.125% for a smoking cessation rate greater than 28%; a penalty of 0.25% will be assessed for a smoking cessation rate less than the current baseline of 21%.

Each MCO's QAPI program must also include four MCO initiated performance improvement projects (PIP), at least one of which must have a behavioral health focus (NH Medicaid Care Management Contract Section 20.1.11). After MCO has had the opportunity to make an initial assessment its membership and, in consultation with its member and provider advisory boards, determined the greatest health care quality improvement opportunity based for its members,

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consistent with 42 CFR 438.240, the State will review and approve the MCO PIP project proposals.

Section 9 of the NH Medicaid Care Management contract requires each MCO to annually submit and implement payment reform strategies. DHHS will withhold 1% of the capitated payments, which MCOs will recoup when implementation milestones from the Payment Reform Incentive Plan have been achieved. The MCO payment reform proposals must comply with all state and federal regulations and the NH Medicaid Care Management Contract (Section 9).

Section 32 of the NH Medicaid Care Management Contract stratifies MCO violations into 5 levels, each with an associated financial remedy. Category 1, the highest level, for example, would be levied against an MCO for a failure to provide medically necessary services at a cost of $100,000/violation; failure to meet telephone inquiries performance standards is an example of Category 5 violation with a lesser fine of $1,000/violation.

*Convening Cross-MCO Quality Activities*
The State will convene Quality Assurance and Improvement meetings with the Medical Directors and Quality Improvement Directors shortly after implementation. These quarterly meetings will routinely bring the State and all three MCOs quality teams together, take a population perspective on NH Medicaid program, and, to the greatest degree possible, harmonize of quality initiatives across the NH Medicaid program.

*EQRO Technical Review and Report*
The State's EQRO Technical Report will include an assessment of each MCOs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients, recommendations for improving the quality of health care services furnished by each MCO, comparative information about all of the State's MCOs, and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year, after the first year of NH Medicaid Care Management program operations. This information will be used to inform any needed benefit changes, NH Medicaid Care Management Contract amendments, additional MCO quality improvement activities, sanctions or other program changes. Additionally, the EQRO report will be used to inform the State of any needed oversight or regulatory support to improve managed care health care delivery.

**B. And C. Proposed Progress Toward Meeting Quality Objectives**
The State will routinely perform the following mandatory quality assurance activities:

- Quality Indicators monitoring, through NH Medicaid Quality Indicators (Appendix C and D),
- MCO Quality Planning and Operations, through the MCO Quality Assessment and Performance Improvement plans
- Quality Projects, including the PIP, QIP, Payment Reform projects
- External organization reviews, through NCQA accreditation review, including HEDIS and CAHPS results and the EQRO activities and Technical Report
- Standardized routine reporting, through required MCO operations and other contractual reports (Appendix G), and the NH DHHS Office of Medicaid

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Business and Policy, Bureau Healthcare Analytics and Data Systems Population-based and ad hoc analysis,
- MCO NCQA accreditation review, and
- External Quality Review Organization (EQRO) Reports

The results of these assessments will inform any improvements or changes needed to ensure high quality health care delivery and optimize Medicaid recipient health outcomes.

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## IV. Review of Quality Strategy

### A. Public Input

The quality strategy was designed during the initial MCO procurement and contracting timeframe and prior to implementation of the Care Management program. During this process, the State looked to 42 CFR 438.200, the CMS State Quality Strategy Tool Kit for State Medicaid and Children's Health Insurance Agencies, the quality strategies of other states and DHHS staff to develop an initial framework. The State will distribute and post the quality strategy prior to the implementation of its Care Management program, modifying the strategy after receiving additional public comments. The State will submit its Quality Strategy to CMS prior to program launch.

After the implementation of the Care Management program, the State will participate in each MCO's advisory committees composed of representatives the provider community (primary care and specialty care), patient and family caregivers MCO members, the advocacy community, and MCO staff. These committees will provide a forum for stakeholders to be actively engaged in MCO quality improvements, raise issues and concerns and discuss possible solutions and provide advice and recommendations on a wide range of issues.

The State will also conduct Quality Assurance and Improvement meetings with the Medical Directors and Quality Improvement Directors shortly after implementation. These quarterly meetings will routinely bring the State and all three MCOs quality teams together, take a population perspective on NH Medicaid program, and, to the greatest degree possible, harmonize of quality initiatives across the NH Medicaid program.

In addition to input from these committees, the quality strategy and any supporting reports or documents will place on the DHHS NH Medicaid Care Management website at: http://www.dhhs.nh.gov/ocom/care-management.htm and be available for ongoing public review and comment.

### B. Strategy Assessment Timeline

Triennially, NH DHHS will comprehensively assess the Quality Strategy, MMIS Reporting Repository database, the MCO Annual Report, the NCQA accreditation process, HEDIS and CAHPS surveys, other data collected by NH Medicaid such as the Comprehensive Healthcare Information System database (all payer claims database, managed by NH DHHS), the findings

from the EQRO Technical Report Evaluation of Improvement Initiatives and the Strengths and Opportunities for Improvement NH Medicaid Care Management Contract Sections.

*Timeline for Quality Strategy for the NH Medicaid Managed Care Program – Assessment of Objectives*

| Quality Strategy Activity | Date Complete |
|---|---|
| Post Draft Quality Strategy for Step One for Public Comment | July 15, 2012 |
| Submit Step One Quality Strategy to CMS | August 15, 2012 |
| Post Final Quality Strategy | October 1, 2012 |
| | |
| Monitor Interim Performance Results | Continuously |
| | |
| Post Draft Quality Strategy for Step Two for Public Comment | 60 days prior to Step Two |
| Submit Step Two Quality Strategy to CMS | 30 days prior to Step Two |
| Post Final Updated Quality Strategy | TBD |
| Monitor Interim Performance Results | Continuously |
| | |
| Post Draft Quality Strategy for Step Three for Public Comment | 60 days prior to Step Three |
| Submit Step Three Quality Strategy to CMS | 30 days prior to Step Three |
| Post Final Updated Quality Strategy | TBD |
| Monitor Interim Performance Results | Continuously |
| | |
| Post Triennial Update Draft Quality Strategy for Public Comment | 60 days prior |
| Submit Triennial Update Quality Strategy to CMS | 30 days prior |
| Post Final Updated Quality Strategy | TBD, Three years after Step Three update |

## V. Achievements and Opportunities

The most up to date achievements in quality improvement will be presented on the NH Medicaid Quality Indicators website, but will also be included in each MCO's annual report and the EQRO annual Technical Report; both of these reports will be accessible from the NH Medicaid Care Management website. Additional program successes will be shared with the Department Public Information Office. Every three years, at minimum, the Quality Strategy will be formally reviewed and amended to reflect and retain programmatic successes and to address new or unmet quality improvement opportunities.

## Appendix A: NH Medicaid Care Management Program Covered Populations and Services Matrix

The planned three-step phase-in of population groups and service is depicted in the Tables below.

| Members | Step 1 | Step 2 | Step 3 | Excluded/ FFS |
|---|---|---|---|---|
| OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals[3] | X | | | |
| Foster Care - With Member Opt Out | X | | | |
| Foster Care - Mandatory Enrollment (w/CMS waiver) | | X | | |
| HC-CSD (Katie Becket) - With Member Opt Out | X | | | |
| CHIP (transition to Medicaid expansion) | X | | | |
| TPL (non-Medicare) except members with VA benefits | X | | | |
| Auto eligible and assigned newborns | X | | | |
| Breast and Cervical Cancer Program (BCCP) | X | | | |
| Medicare Duals - With Member Opt Out | X | | | |
| Medicare Duals - Mandatory Enrollment (w/CMS waiver) | | X | | |
| ACA Expansion Group | | | X | |
| Members with VA Benefits | | | | X |
| Family Planning Only Benefit (in development) | | | | X |
| Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns) | | | | X |
| Spend-down | | | | X |
| QMB/SLMB Only (no Medicaid) | | | | X |

| Covered Services Matrix | Step 1 | Step 2 | Step 3 | Excluded/ FFS |
|---|---|---|---|---|
| Maternity & Newborn Kick Payments | X | | | |

[3] Per 42 USC §1396u-2(a)(2)(A)Non-dual members under age 19 receiving SSI, or with special healthcare needs, or who receive adoption assistance or are in out of home placements, have member opt out.

| Covered Services Matrix | Step 1 | Step 2 | Step 3 | Excluded/ FFS |
|---|---|---|---|---|
| Inpatient Hospital | X | | | |
| Outpatient Hospital | X | | | |
| Inpatient Psychiatric Facility Services Under Age 22 | X | | | |
| Physicians Services | X | | | |
| Advanced Practice Registered Nurse | X | | | |
| Rural Health Clinic & FQHC | X | | | |
| Prescribed Drugs | X | | | |
| Community Mental Health Center Services | X | | | |
| Psychology | X | | | |
| Ambulatory Surgical Center | X | | | |
| Laboratory (Pathology) | X | | | |
| X-Ray Services | X | | | |
| Family Planning Services | X | | | |
| Medical Services Clinic (mostly methadone clinic) | X | | | |
| Physical Therapy | X | | | |
| Occupational Therapy | X | | | |
| Speech Therapy | X | | | |
| Audiology Services | X | | | |
| Podiatrist Services | X | | | |
| Home Health Services | X | | | |
| Private Duty Nursing | X | | | |
| Adult Medical Day Care | X | | | |
| Personal Care Services | X | | | |
| Hospice | X | | | |
| Optometric Services Eyeglasses | X | | | |

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| Covered Services Matrix | Step 1 | Step 2 | Step 3 | Excluded/ FFS |
|---|---|---|---|---|
| Furnished Medical Supplies & Durable Medical Equipment | X | | | |
| Non-Emergent Medical Transportation | X | | | |
| Ambulance Service | X | | | |
| Wheelchair Van | X | | | |
| Fluoride Varnish by Primary Care Physicians | X | | | |
| Acquired Brain Disorder Waiver Services | | X | | |
| Developmentally Disabled Waiver Services | | X | | |
| Choices for Independence Waiver Services | | X | | |
| In Home Supports Waiver Services | | X | | |
| Skilled Nursing Facility | | X | | |
| Skilled Nursing Facility Atypical Care | | X | | |
| Inpatient Hospital Swing Beds, SNF | | X | | |
| Intermediate Care Facility Nursing Home | | X | | |
| Intermediate Care Facility Atypical Care | | X | | |
| Inpatient Hospital Swing Beds, ICF | | X | | |
| Glencliff Home | | X | | |
| Developmental Services Early Supports and Services | | X | | |
| New Substance Abuse Benefit Allowing MLDACs | | X | | |
| Home Based Therapy – DCYF | | X | | |
| Child Health Support Service – DCYF | | X | | |
| Intensive Home and Community Services – DCYF | | X | | |
| Placement Services – DCYF | | X | | |
| Private Non-Medical Institutional For Children – DCYF | | X | | |
| Crisis Intervention – DCYF | | X | | |
| Intermediate Care Facility MR | | | | X |

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| Covered Services Matrix | Step 1 | Step 2 | Step 3 | Excluded/ FFS |
|---|---|---|---|---|
| Medicaid to Schools Services | | | | X |
| Dental Benefit Services | | | | X |

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## Appendix B: Quality Incentive Program Measures

Increasing Adolescent Well Care Visits, a Healthcare Effectiveness Data and Information Set (HEDIS) measure

Measure Technical Definition: Measure Technical Definition: The percentage of continuously enrolled members aged 12-21 years of age as of December 31 of the year measures who had at least one comprehensive well-care visit with a PCP or OB/GYN. Measure is based on the standard HEDIS definition for Adolescent Well-Care Visit measure published by National Committee for Quality Assurance (NCQA) for the measurement year using administrative (claims) data.

Reducing 30 day and 180 day Readmissions to New Hampshire Hospital, New Hampshire's state run inpatient psychiatric facility, a Substance Abuse and Mental Health Services Administration (SAMHSA) measure

Measure Technical Definition: The total number of admissions to New Hampshire Hosptial that occurred within 30 and 180 days following a discharge event from New Hampshire Hosptial divided by the total number of discharges from New Hampshire Hospital during the reporting year. The 180 day readmission measure includes persons who were readmitted within 30 days (e.g., the 180 day readmission calculation includes all individuals with a readmission between 0 and 180 days). A readmission is defined as returned to any state hospital without contingency; this would exclude those who were not discharged, including on leave, visits, leaves without consent, and elopements. Persons who are discharged for the purpose of receiving medical treatment in another facility who return to the state psychiatric hospital should not be counted as a readmission when they return to the psychiatric hospital. (Numerator) The total number of discharges from a state operated psychiatric hospital inpatient unit (not unduplicated). Discharged is defined as released from the hospital without contingency; this would exclude those who are released on leave, including visits, leaves without consent, discharges for medical treatment. (Denominator) In order to measure all readmissions that occur within 30 or 180 days of discharge, a state must count readmissions that occur over a longer period of time than just a 12-month period. For example, the 30 day readmission rate the numerator is based on readmissions in a 13 month period. For the 180 day readmission rate, the numerator is based on readmissions in an 18 month period.

Improvement in Getting Needed Care, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure

Measure Technical Definition: Measure Technical Definition: The weighted average of the Agency for Healthcare Research and Quality (AHRQ) Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) composite measures for getting needed care "usually" or "always" based on MCO member survey responses. The two questions that make up the composite measure are:

- How often was it easy to get appointments with specialists?
- How often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

The CAHPS survey specification asks adults these questions about the past 12 months and caregivers of children about the past 6 months. The MCO will use the most recent version of the CAHPS survey for both adults and children. The survey can be the same survey performed to meet the CAHPS requirement of the quality reporting requirements of the contract. Because different surveys must be administered to adults and children, a weighted average will be taken based on the MCO population of adult and child members. The MCO will perform the weighted average calculation and detail it for verification by DHHS.

Improving Maternal Smoking Cessation, a DHHS measure

Measure Technical Definition: The number of enrolled pregnant women who self-reported smoking before or during their pregnancy and stopped smoking by third trimester (Numerator), over the total number of enrolled pregnant women who smoked before or during their pregnancy (Denominator). Both Numerator and Denominator are restricted to those pregnant women enrolled in the MCO prior to the third trimester as well as enrolled at the time of the delivery. Vital Records data is the source of the information on smoking use and cessation.

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## Appendix C: NH Medicaid Quality Indicators - Website and Measure Texts

*Last Updated 4.24.12. Consult with the Department for any recent updates prior to use.*

Welcome to the NH Medicaid Quality Indicators

Public stewardship of the NH Medicaid program requires an understanding of the quality and effectiveness of program services and the impact of those services on the health and well being of Medicaid recipients. This site allows recipients, providers, and policy makers to view population-based health snapshots of people served by the Medicaid program. These Medicaid Quality Indicators will assist readers in identifying program strengths and opportunities for improvement.

How to Use the NH Medicaid Quality Indicators

The Medicaid Quality Indicators aggregate numerous internal and external data sources to create population-based snapshots of Medicaid recipient health. Each web page identifies the data source and time frame used for the Medicaid and comparison groups presented. Comparisons have been drawn from the most relevant population and time frame for which data is available. Included in this data are only non-dually enrolled Medicaid recipients. Dually enrolled recipients are covered by both Medicaid and Medicare; non-dually enrolled do not have additional Medicare coverage.

Each measure includes a "Measure Technical Definition" and "Measure Relevance." The Measure Technical Definition is a description of how the measure was calculated. The Measure Relevance provides a description of why the measure is important and how this importance was determined.

At this time, the data is presented without benchmarking. As state and national benchmarking information becomes available, this information will be added to the site. Additional measures will also be added over time.

For additional information and questions regarding the NH Medicaid Quality Indicators, contact: NHMedicaidQualityIndicators@dhhs.state.nh.us

### Indicators

Ambulatory Care Sensitive Conditions (ACSC) - Adult Admissions per 1000

Measure Technical Definition: The number of inpatient admissions for ambulatory care sensitive conditions (ACSC) by non-dually enrolled adults (Numerator), over the total number of non-dually enrolled adults (Denominator). The ambulatory care sensitive conditions (ACSC) included in this measure are: asthma, dehydration, bacterial pneumonia, urinary tract infection, and gastroenteritis. [Note: the denominator is divided by 1000 to calculate the rate per 1000]

Measure Relevance: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of appropriate primary healthcare delivery. While not all admissions for these conditions are avoidable, appropriate ambulatory care can help prevent, or control, acute episodes, and improve the management of these illnesses or conditions. A disproportionately high rate of ACSC admissions may reflect under-utilization of appropriate primary care.

Ambulatory Care Sensitive Conditions (ACSC) - Child Admissions per 1000

Measure Technical Definition: The number of inpatient admissions for ambulatory care sensitive conditions (ACSC) by non-dually enrolled children (Numerator), over the total number of non-dually enrolled children (Denominator). The ambulatory care sensitive conditions (ACSC) included in this measure are: asthma, dehydration, bacterial pneumonia, urinary tract infection, and gastroenteritis. [Note: the denominator is divided by 1000 to calculate the rate per 1000]

Measure Relevance: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of appropriate primary healthcare delivery. While not all admissions for these conditions are avoidable, appropriate ambulatory care can help prevent, or control, acute episodes, and improve the management of these

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illnesses or conditions. A disproportionately high rate of ACSC admissions may reflect under-utilization of appropriate primary care.

### Ambulatory Care Sensitive Conditions (ACSC) - Total Admissions per 1000

Measure Technical Definition: The number of inpatient admissions for ambulatory care sensitive conditions (ACSC) by non-dually enrolled children and adults (Numerator), over the total number of non-dually enrolled children and adults (Denominator). The ambulatory care sensitive conditions included in this measure are: asthma, dehydration, bacterial pneumonia, urinary tract infection, and gastroenteritis. [Note: the denominator is divided by 1000 to calculate the rate per 1000]

Measure Relevance: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of appropriate primary healthcare delivery. While not all admissions for these conditions are avoidable, appropriate ambulatory care can help prevent, or control, acute episodes, and improve the management of these illnesses or conditions. A disproportionately high rate of ACSC admissions may reflect under-utilization of appropriate primary care.

### Asthma - Admissions for Asthma per 1000 Adults with Asthma

Measure Technical Definition: The number of inpatient admissions for asthma and asthma related conditions during the measurement year by non-dually enrolled adults with a diagnosis of asthma, (Numerator), over the total number of non-dually enrolled adults with a diagnosis of asthma (Denominator). [Note: the denominator is divided by 1000 to calculate the rate per 1000]

Measure Relevance: This indicator measures hospitalizations for asthma where asthma and asthma related conditions are identified as the main reason for hospitalization. Adherence to guidelines outlining maintenance therapies may reduce the incidence of acute exacerbations requiring hospitalization.

### Asthma - Admissions for Asthma per 1000 Children with Asthma

Measure Technical Definition: The number of inpatient admissions for asthma and asthma related conditions during the measurement year by non-dually enrolled children with a diagnosis of asthma, (Numerator), over the total number of non-dually enrolled children with a diagnosis of asthma (Denominator). [Note: the denominator is divided by 1000 to calculate the rate per 1000]

Measure Relevance: This indicator measures hospitalizations for asthma, where asthma and asthma related conditions is identified as the main reason for hospitalization. Adherence to guidelines outlining maintenance therapies may reduce the incidence of acute exacerbations requiring hospitalization.

### Asthma - ED Visits for Asthma per 1000 Adults with Asthma

Measure Technical Definition: The number of Emergency Department visits for asthma and asthma related conditions during the measurement year by non-dually enrolled adults with a diagnosis of asthma (Numerator), over the total number of non-dually enrolled adults with a diagnosis of asthma and asthma related conditions (Denominator). [Note: the denominator is divided by 1000 to calculate the rate per 1000]

Measure Relevance: This indicator measures emergency department visits for asthma, where asthma is identified as the main reason for the visit. Adherence to guidelines outlining maintenance therapies may reduce the incidence of acute exacerbations requiring emergency department visits.

### Asthma - ED Visits for Asthma per 1000 Children with Asthma

Measure Technical Definition: The number of Emergency Department visits for asthma and asthma related conditions during the measurement year by non-dually enrolled children with a diagnosis of asthma (Numerator), over the total number of non-dually enrolled children with a diagnosis of asthma and asthma related conditions (Denominator). [Note: the denominator is divided by 1000 to calculate the rate per 1000]

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Measure Relevance: This indicator measures emergency department visits for asthma, where asthma is identified as the main reason for the visit. Adherence to guidelines outlining maintenance therapies may reduce the incidence of acute exacerbations requiring emergency department visits.

### Breast Cancer Screening

Measure Technical Definition: The number of continuously non-dually enrolled women of who had a screening mammogram during measurement year or year prior (Numerator) over the total number of continuously non-dually enrolled same-aged women (Denominator).

Measure Relevance: The United States Public Services Task Force (USPSTF) recommends mammography once every two years for all women 50 years and older for breast cancer screening in the general population. Increased screening may reduce the adverse outcomes associated with breast cancer.

### Cervical Cancer Screening

Measure Technical Definition: The number of continuously non-dually enrolled women who had cervical cancer screening during measurement year or 2 years prior (Numerator), over the total number of continuously non-dually enrolled same-aged women (Denominator).

Measure Relevance: The United States Public Services Task Force (USPSTF) recommends cervical cancer screening at least once every 3 years for all women 21 years and older. Increased screening may reduce adverse outcomes associated with cervical cancer.

### Chlamydia Screening

Measure Technical Definition: The number of women with at least one test for chlamydia screening during measurement year (Numerator), over the total number of continuously non-dually enrolled same-aged women who self identify as being sexually active (Denominator).

Measure Relevance: Chlamydia is the most common sexually transmitted disease in the United States. Chlamydia infection is associated with increased risk of pelvic infections, infertility and complications during pregnancy. The United States Public Services Task Force (USPSTF) recommends screening for chlamydia for all sexually active women 21 years and older as well as sexually active women under 21 years. Increased screening may reduce the adverse outcomes associated with chlamydia.

### Chronic Obstructive Pulmonary Disease (COPD) - Admissions for COPD per 1000 Recipients with COPD

Measure Technical Definition: The number of inpatient admissions for COPD related conditions during the measurement year by non-dually enrolled adults with a diagnosis of COPD (Numerator), over the total number of non-dually enrolled adults with a diagnosis of COPD (Denominator). [Note: the denominator is divided by 1000 to calculate the rate per 1000].

Measure Relevance: Chronic obstructive pulmonary disease (COPD) comprises three primary diseases that cause respiratory dysfunction--asthma, emphysema, and chronic bronchitis. This indicator measures admissions for COPD, where COPD is identified as the main reason for hospital admission. Adherence to guidelines outlining therapies and smoking cessation may reduce the incidence of acute exacerbations requiring hospitalization.

### Chronic Obstructive Pulmonary Disease (COPD) - ED Visits for COPD per 1000 Recipients with COPD

Measure Technical Definition: The number of Emergency Department visits for COPD related conditions during the measurement year by non-dually enrolled adults with a diagnosis of COPD (Numerator), over the total number of non-dually enrolled adults with a diagnosis of COPD (Denominator). [Note: the denominator is divided by 1000 to calculate the rate per 1000]

Measure Relevance: Chronic obstructive pulmonary disease (COPD) comprises three primary diseases that cause respiratory dysfunction--asthma, emphysema, and chronic bronchitis. This indicator measures emergency department visits for COPD, where COPD is identified as the main reason for visit. Adherence to guidelines

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outlining therapies and smoking cessation may reduce the incidence of acute exacerbations requiring emergency department visits.

### Colorectal Cancer Screening

Measure Technical Definition: The number of continuously non-dually enrolled adults who had appropriate colon cancer screening defined by the United States Public Services Task Force (USPSTF) as 1) Fecal Occult Blood testing during measurement year, or 2) Flexible sigmoidoscopy during measurement year or four years prior, or 3) colonoscopy during measurement year or 9 years prior (Numerator), over the total number of continuously non-dually enrolled same-aged adults (Denominator).

Measure Relevance: The United States Public Services Task Force (USPSTF) currently recommends colon cancer screening once every 10 years for all adults beginning at 50 years and continuing to 75 years in the general population. Increased screening may reduce the adverse outcomes associated with colon cancer.

### Comprehensive Diabetes Care - Glycosylated Hemoglobin (HbA1c) Testing

Measure Technical Definition: The number of continuously non-dually enrolled adults with a diagnosis of diabetes mellitus who received glycosylated hemoglobin (HbA1c) testing during measurement year (Numerator), over the total number of continuously non-dually enrolled same-aged adults with a diagnosis of diabetes mellitus (Denominator).

Measure Relevance: Reductions in HbA1C to a target of HbA1C <7 reduces the risk of diabetes complications such as retinopathy, nephropathy, and neuropathy. The American Diabetes Association currently recommends at least twice yearly HbA1c testing. Routine testing assists in the management of diabetes and achieving better glucose control may reduce the adverse outcomes associated with diabetes.

### Comprehensive Diabetes Care - Annual Low-density Lipoproteins (LDL) Testing

Measure Technical Definition: The number of continuously non-dually enrolled adults with a diagnosis of diabetes mellitus who received LDL lipid screening during measurement year (Numerator), over the total number of continuously non-dually enrolled same-aged adults with a diagnosis of diabetes mellitus (Denominator).

Measure Relevance: High levels of LDL are associated with an increased risk of cardiovascular disease. The American Diabetes Association currently recommends at least once yearly LDL testing. Routine testing assists in the management of LDL and reducing LDL may reduce the adverse outcomes of cardiovascular disease associated with diabetes.

### Comprehensive Diabetes Care - Annual Diabetic Retinal Exams

Measure Technical Definition: The number of continuously non-dually enrolled recipients with a diagnosis of diabetes mellitus who received diabetic retinal exam during measurement year (Numerator), over the total number of continuously non-dually, same-aged enrolled adults with a diagnosis of diabetes mellitus (Denominator).

Measure Relevance: People with diabetes may experience several eye problems as a complication of diabetes that can cause severe vision loss or even blindness. The American Diabetes Association currently recommends retinopathy screening at least once every year. Routine screening assists in the recognition and management of retinopathy and may reduce the adverse eye diseases associated with diabetes.

### Congestive Heart Failure (CHF) - Admissions for CHF per 1000 Recipients with CHF

Measure Technical Definition: The number of inpatient admissions for CHF related conditions during the measurement year by non-dually enrolled adults with a diagnosis of CHF (Numerator), over the total number of non-dually enrolled, same-aged adults with a diagnosis of CHF (Denominator). [Note: the denominator is divided by 1000 to calculate the rate per 1000]

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Measure Relevance: This indicator measures hospitalizations for CHF, where CHF is identified as the main reason for hospitalization. Adherence to guidelines outlining therapies and diet may reduce the incidence of acute exacerbations requiring hospitalization.

### Congestive Heart Failure (CHF) - ED Visits for CHF per 1000 Recipients with CHF

Measure Technical Definition: The number of Emergency Department visits for CHF related conditions during the measurement year by non-dually enrolled adults with a diagnosis of CHF (Numerator), over the total number of non-dually enrolled, same-aged adults with a diagnosis of CHF (Denominator). [Note: the denominator is divided by 1000 to calculate the rate per 1000]

Measure Relevance: This indicator measures Emergency Department visits for CHF, where CHF is identified as the main reason for the visit. Adherence to guidelines outlining therapies and diet may reduce the incidence of acute exacerbations requiring Emergency Department visits.

### Follow-up After Hospitalization for Mental Illness - within 30 days of discharge

Measure Technical Definition: The number of discharges for non-dually enrolled adults who were hospitalized for treatment of mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge (Numerator), over the total number of non-dually enrolled, same-aged adults discharged after inpatient admission for mental health disorders (Denominator). The mental health disorders resulting in admission included in this measure are: schizophrenic, episodic mood, delusional, non –organic psychoses, developmental, obsessive compulsive, dysthymic, personality, acute stress reaction, adjustment, depression, disturbance of conduct, disturbance of emotion, and hyperkinetic syndrome.

Measure Relevance: Follow up care with a mental health clinical provider within 30 days after psychiatric hospitalization assists in a successful transition back into the community and may reduce mental illness exacerbations and re-hospitalization.

### Follow-up After Hospitalization for Mental Illness - within 7 days of discharge

Measure Technical Definition: The number of discharges for non-dually enrolled adults who were hospitalized for treatment of mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge (Numerator), over the total number of non-dually enrolled, same-aged adults discharged after inpatient admission for mental health disorders (Denominator). The mental health admissions included in this measure are: The mental health disorders resulting in admission include schizophrenic, episodic mood, delusional, non–organic psychoses, developmental, obsessive compulsive, dysthymic, personality, acute stress reaction, adjustment, depression, disturbance of conduct, disturbance of emotion, and hyperkinetic syndrome.

Measure Relevance: Follow up care with a mental health clinical provider within 7 days after psychiatric hospitalization assists in a successful transition back into the community and may reduce mental illness exacerbations and re-hospitalization.

### Follow-up Care for Children Prescribed ADHD Medication (ADD) – Maintenance Phase

Measure Technical Definition: The number of non-dually enrolled children who were prescribed an ADHD medication and remained on the medication for at least 210 days and had at least two follow-up visits (total 3 visits) with a practitioner within 270 days (9 months) (Numerator), over the total number of non-dually enrolled, same-aged children who were prescribed and maintained on an ADHD medication for at least 210 days (Denominator). The ADHD medications include only CNS stimulants such as but not limited to: methylphenidate, methamphetamine, and dextroamphetamine.

Measure Relevance: The American Academy of Pediatric Psychiatry recommends periodic monitoring of children on ADHD medications. Medication monitoring assists in achieving treatment outcomes and may reduce acute exacerbations and adverse outcomes associated with ADHD and the use of stimulants for the treatment of ADHD.

### Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase

Measure Technical Definition: The numbers of non-dually enrolled children who were prescribed an ADHD medication and had at least one follow up visit within 30 days of initial prescription (Numerator), over the total number of non-dually enrolled, same-aged children who were prescribed an ADHD medication. (Denominator). The ADHD medications include only CNS stimulants such as but not limited to: methylphenidate, methamphetamine, and dextroamphetamine.
Measure Relevance: The American Academy of Pediatric Psychiatry recommends periodic monitoring of children on ADHD medications. Medication monitoring assists in achieving treatment outcomes and may reduce acute exacerbations and adverse outcomes associated with ADHD and the use of stimulants for the treatment of ADHD.

### Percentage of Adults Admitted to a Hospital for Any Condition

Measure Technical Definition: The number of non-dually enrolled adults with an inpatient hospital admission for any health related condition excluding maternity (Numerator), over the total number of non-dually enrolled same-aged adults (Denominator).
Measure Relevance: This indicator measures acute hospital utilization for adult Medicaid recipients.

### Percentage of Adults with One or More Primary Care Provider (PCP)

Measure Technical Definition: The number of non-dually enrolled adults who self-identify as having a PCP (Numerator), over the total number of non-dually enrolled adults (Denominator).
Measure Relevance: Healthy People 2020 recommends having a PCP. Having a regular PCP may be associated with an increased likelihood of receiving appropriate care.

### Percentage of Children Admitted to a Hospital for Any Condition

Measure Technical Definition: The number of non-dually enrolled children with an inpatient hospital admission for any health related condition excluding maternity and newborns (Numerator), over the total number of non-dually enrolled, same-aged children (Denominator).
Measure Relevance: This indicator measures acute hospital utilization for child Medicaid recipients.

### Percentage of Total Admissions to a Hospital for Any Condition

Measure Technical Definition: The number of non-dually enrolled children and adults with an inpatient hospital admission for any health related condition excluding maternity and newborns (Numerator), over the total number of non-dually enrolled, same-aged children and adults (Denominator).
Measure Relevance: This indicator measures acute hospital utilization for child and adult Medicaid recipients.

### Persistence of Beta-Blocker Treatment After a Heart Attack

Measure Technical Definition: The number of non-dually enrolled adults who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for 6 months after discharge (Numerator), over the total number of non-dually enrolled, same-aged adults, hospitalized and discharged alive during the same timeframe with a diagnosis of acute myocardial infarction (AMI) (Denominator).
Measure Relevance: The American College of Cardiology and the American Heart Association recommend the use of beta-blocker therapy following AMI. Increased beta-blocker treatment following AMI may decrease complications and death following AMI.

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### Upper Respiratory Infection (URI) - Appropriate Treatment for Children with URI

Measure Technical Definition: The number non-dually enrolled children diagnosed with upper respiratory infection (URI) and not dispensed an antibiotic prescription until three days after the Index Episode Start Date (IESD)(Numerator), over the total number of non-dually enrolled, same-aged children diagnosed with URI (Denominator).

Measure Relevance: Most common colds, or upper respiratory infections (URI), are caused by viruses. Inappropriate antibiotic use for viral URIs can lead to antibiotic resistance and reduced effectiveness of appropriate antibiotic use. Increased adherence to clinical practice guidelines may decrease the inappropriate use of antibiotics for upper respiratory infections.

### Use of Appropriate Medications for People with Asthma

Measure Technical Definition: The number of non-dually enrolled children and adults with a diagnosis of persistent asthma who where prescribed appropriate medications (Numerator), over the total number of non-dually enrolled, same-aged children and adults with a diagnosis of persistent asthma (Denominator). The National Heart, Lung, and Blood Institute (NHLBI) Guidelines defines mild-to-moderate persistent asthma as asthma that produces daily symptoms and/or nighttime symptoms more than five times a month and/or requires medicines to reduce symptoms every day. The list of appropriate medications is determined by the National Heart, Lung, and Blood Institute (NHLBI) National Asthma Education Prevention Program (NAEPP) guidelines.

Measure Relevance: Asthma is one of the nation's most costly and high-impact diseases. Many asthma-related deaths, hospitalizations, emergency room visits, missed work and school days could be avoided if patients had appropriate medications and medical management. This indicator measures whether children and adults with persistent asthma are being prescribed medications for long-term asthma control. Adherence to clinical practice guidelines and an increased use of appropriate medications may improve asthma control and reduce the adverse outcomes associated with asthma.

### Well-Care Visit for Adolescents Aged 12 to 21 Years

Measure Technical Definition: The number of non-dually enrolled adolescents who had at least one well child visit with PCP or OB/GYN during the measurement year (Numerator), over the total number of non-dually enrolled, same-aged adolescents (Denominator).

Measure Relevance: This indicator measures the use of routine check-ups by adolescents. It measures the percentage of adolescents between 12-21 years who received at least one well-child visit with a primary care practitioner or OB/GYN during the measurement year. Well child visits can provide education and guidance to children and their caregivers; provide preventive services, like immunizations; and screen for other health concerns. The American Academy of Pediatrics recommends annual well child visits for 12-21 years. Adherence to guidelines may decrease the adverse outcomes associated with health concerns and increase the overall health of children.

### Well-Child Visits in the First 15 Months of Life

Measure Technical Definition: The number of non-dually enrolled children between 31 days - 15 months of age who had completed at least six Well Child Visit with PCP during the measurement year (Numerator), over the total number of non-dually enrolled, same-aged children (Denominator).

Measure Relevance: This indicator measures the use of routine check-ups by young children. It measures the percentage of children from 31 days through 15 months who received at least one well-child visit with a primary care practitioner during the measurement year. Well child visits can provide education and guidance to children and their caregivers; provide preventive services, like immunizations; and screen for other health concerns. The American Academy of Pediatrics recommends 6 well child visits in the first 15 months of life. Adherence to guidelines may decrease the adverse outcomes associated with health concerns and increase the overall health of children.

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### Well-Child Visits of Children 3 to 6 Years of Age

Measure Technical Definition: The number of non-dually enrolled children ages 3 to 6 years by December 31 of the measurement year who had at least one Well Child Visit with PCP during the measurement year (Numerator), over the total number of non-dually enrolled, same-aged children (Denominator).

Measure Relevance: This indicator measures the use of routine check-ups by preschool and early school-age children. It measures the percentage of children from 3 to 6 years who received at least one well-child visit with a primary care practitioner during the measurement year. Well child visits can provide education and guidance to children and their caregivers; provide preventive services, like immunizations; and screen for other health concerns. The American Academy of Pediatrics recommends annual well child visits for children aged 3 to 6 years. Adherence to guidelines may decrease the adverse outcomes associated with health concerns and increase the overall health of children

### Well-Child Visits of Children 7 to 11 Years of Age

Measure Technical Definition: The number of non-dually enrolled children ages 7 to 11 years by December 31 of the measurement year who had at least one well child visit with PCP during the measurement year (Numerator), over the total number of non-dually continuously enrolled, same-aged children (Denominator).

Measure Relevance: This indicator measures the use of routine check-ups by school-age children. It measures the percentage of children from 7 to 11 years who received at least one well-child visit with a primary care practitioner during the measurement year. Well child visits can provide education and guidance to children and their caregivers; provide preventive services, like immunizations; and screen for other health concerns. The American Academy of Pediatrics (AAP) recommends annual well child visits for children aged 7 to 11 years. Adherence to guidelines may decrease the adverse outcomes associated with health concerns and increase the overall health of children.

### Well-Child Visits of Children aged 16 to 35 Months of Age

Measure Technical Definition: The number of non-dually enrolled children of pertaining age who had at least one well child visit with PCP during the measurement year (Numerator), over the total number of non-dually enrolled, same-aged children (Denominator).

Measure Relevance: This indicator measures the use of routine check-ups by young and preschool-age children. It measures the percentage of children from 16 to 35 months who received at least one well-child visit with a primary care practitioner during the measurement year. Well child visits can provide education and guidance to children and their caregivers; provide preventive services, like immunizations; and screen for other health concerns. The American Academy of Pediatrics recommends four well child visits between 16 to 35 months. Adherence to guidelines may decrease the adverse outcomes associated with health concerns and increase the overall health of children.

### Cigarette Smoking by Adult Medicaid Recipients

Measure Technical Definition: The number of non-dually enrolled adults who self report having smoked greater than or equal to 100 cigarettes in their lifetime and are current smokers on every day or some days (Numerator), over the number of non-dually enrolled, same-aged adults with the same history of cigarette use (Denominator).

Measure Relevance: This indicator measures the amount of self-reported cigarette smoking. Cigarette smoking is the leading preventable cause of death in the United States. Smoking increases the risk of many diseases including: heart disease, cancer, stroke, and chronic lung disease, among others. Smoking cessation may decrease the adverse outcomes associated with cigarette use.

### Percentage of Binge Drinkers

Measure Technical Definition: The number of non-dually enrolled adults who self report having ≥ 5 drinks (men) or ≥4 drinks (women) on one or more occasions during the previous 30 days (Numerator), over the number of non-dually enrolled, same-aged adults with the same history of alcohol use (Denominator).

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Measure Relevance: This indicator measures the amount of self-reported drinking. The National Institute on Alcohol Abuse and Alcoholism and the Center for Disease Control and Prevention define binge drinking as ≥ 5 drinks (men) or ≥4 drinks (women) on one or more occasions over 30 days. Excessive alcohol use is strongly associated with injuries, violence, fetal alcohol syndrome, chronic liver disease, and risk of other acute and chronic health effects. Reductions in alcohol consumption may decrease the adverse outcomes associated with alcohol use.

### Percentage of Obese Adults

Measure Technical Definition: The number of non-dually enrolled adults who have a Body Mass Index (BMI) ≥ 30 $kg/m^2$ based on self reported height and weight (Numerator), over the number of non-dually enrolled, same-aged adults (Denominator).

Measure Relevance: This indicator measures the percent of adults who self-reported height and weight and then calculates a BMI. The Center for Disease Control and Prevention defines a BMI ≥ 30 $kg/m^2$ as obese. Obesity increases the risk of many diseases including: an increased risk for coronary heart disease, hypertension, and stroke; type 2 diabetes; several types of cancer, including those of the colon, kidney, gallbladder, breast, and endometrium; sleep apnea; gall bladder disease; and certain musculoskeletal disorders, such as knee osteoarthritis, among others. Reductions in BMI may decrease the adverse outcomes associated with obesity.

### Percentage of Overweight Adults

Measure Technical Definition: The number of non-dually enrolled adults who have a Body Mass Index (BMI) ≥ 25 $kg/m^2$ based on self reported height and weight (Numerator), over the number of non-dually enrolled, same-aged adults (Denominator).

Measure Relevance: This indicator measures the percent of adults who self-report height and weight and then calculates a BMI. The Center for Disease Control and Prevention defines a BMI ≥ 25 $kg/m^2$ as overweight. Like obesity, being overweight increases the risk of many diseases including: an increased risk for coronary heart disease, hypertension, and stroke; type 2 diabetes; several types of cancer, including those of the colon, kidney, gallbladder, breast, and endometrium; sleep apnea; gall bladder disease; and certain musculoskeletal disorders, such as knee osteoarthritis, among others. Reductions in BMI may decrease the adverse outcomes associated with being overweight.

### Smoking Cessation: Mothers Stopped Smoking by Their Third Trimester of Pregnancy

Measure Technical Definition: The number of enrolled pregnant women who self-reported smoking before or during their pregnancy and stopped smoking by third trimester (Numerator), over the total number of enrolled, same-aged pregnant women who smoked before or during their pregnancy (Denominator).

Measure Relevance: This indicator measures the smoking cessation by the third trimester of pregnancy. Cigarette smoking during pregnancy increases the risk of low birth weight and premature infants, miscarriage, stillbirth, sudden infant death syndrome, and infant mortality. Decreasing tobacco use during pregnancy may decrease the adverse health outcomes associated with smoking for both the pregnant woman and infant.

### Tobacco Use During Pregnancy

Measure Technical Definition: The number of enrolled pregnant women who self-reported smoking during pregnancy (Numerator), over the total number of enrolled, same-aged pregnant women (Denominator).

Measure Relevance: This indicator measures tobacco use during pregnancy. Cigarette smoking during pregnancy increases the risk of low birth weight and premature infants, miscarriage, stillbirth, sudden infant death syndrome, and infant mortality. Decreasing tobacco use during pregnancy may decrease the adverse health outcomes associated with smoking for both the pregnant woman and infant.

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### Pharyngitis - Appropriate Testing for Children with Pharyngitis

Measure Technical Definition: The number of non-dually enrolled children from 2-18 years diagnosed with acute bacterial pharyngitis, prescribed an antibiotic, and tested for group A streptococcus (Numerator), over the total number of non-dually enrolled, same-aged children diagnosed with pharyngitis and a dispensed antibiotic for that episode of care who did not receive testing (Denominator).

Measure Relevance: Testing for group A streptococcus serves as an important indicator of appropriate antibiotic use for all causes of throat infections. A rapid assay or throat culture can reliably confirm the presence of group A streptococcus. The American Academy of Pediatrics recommends that only children with testing confirmed group A streptococcus (strep) pharyngitis be treated with antibiotics. Overuse of antibiotics can contribute to antibiotic resistance. The appropriate use of antibiotics can reduce the levels of antibiotic resistance.

### Smoking Cessation: Adult Smokers Stopped Smoking in Past 12 months

Measure Technical Definition: The number of non-dually enrolled adults who self report having stopped smoking in the past 12 months for the purpose of quitting smoking (Numerator), over the number of non-dually enrolled, same-aged adults with the same history (Denominator).

Measure Relevance: This indicator measures the amount of self-reported smoking cessation for the purpose of quitting smoking. Cigarette smoking is the leading preventable cause of death in the United States. Smoking increases the risk of many diseases including: heart disease, cancer, stroke, and chronic lung disease among others. Smoking cessation may decrease the adverse outcomes associated with cigarette use.

### Tobacco Use - Before Pregnancy

Measure Technical Definition: The number of enrolled pregnant women who self-reported smoking before pregnancy (Numerator), over the total number of enrolled, same-aged pregnant women (Denominator). [Note: This data includes pregnant teens]

Measure Relevance: This indicator measures tobacco use before pregnancy. Women who stop smoking before pregnancy or during the first 3 to 4 months of pregnancy reduce the risk of low birth weight and premature infants, miscarriage, stillbirth, sudden infant death syndrome, and infant mortality. Smoking cessation or decreasing tobacco use during pregnancy may decrease the adverse health outcome associated with smoking for both the pregnant woman and infant.

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## Appendix D: NH Medicaid Care Management Required Quality Reporting Measures

As additional measures are added to the NCQA or CMS measure sets, the NH Medicaid Care Management MCO reporting requirements shall include those new measures. For measures that are no longer part of the measures sets, DHHS may at its option add those measures to the Additional State Required Measure list. *Last Updated 7.2.12. Consult with the Department for any recent updates prior to use.*

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Adherence to Antipsychotics for Individuals with Schizophrenia | Management of Chronic Conditions | CMS-QMHAG | | | X | |
| Adolescent Well-Care Visits | Use of Services | NCQA/CAHPS | | X | | |
| Adult Asthma Admission Rate (PQI 15) | Prevention and Health Promotion | AHRQ | | | X | |
| Adult BMI Assessment | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Adult Survey - Flu Shots for Adults Ages 50-64 | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Adults' Access to Preventive/Ambulatory Health Services (20-44) | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Adults' Access to Preventive/Ambulatory Health Services (45-64) | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Adults' Access to Preventive/Ambulatory Health Services (65+) | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Adults' Access to Preventive/Ambulatory Health Services (Total) | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Ambulatory Care: Emergency Dept Visits/1000 | Use of Services | NCQA/CAHPS | | | | X |
| Ambulatory Care: Emergency Dept Visits/1000 Children | Use of Services | NCQA/CAHPS | | X | | |
| Annual HIV/AIDS Medical Visit | Management of Chronic | NCQA/CAHPS | | | X | |

| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| | Conditions | | | | | |
| Annual Monitoring for Patients on Persistent Medications - ACE or ARB | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Annual Monitoring for Patients on Persistent Medications - Anticonvulsants | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Annual Monitoring for Patients on Persistent Medications - Digoxin | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Annual Monitoring for Patients on Persistent Medications - Diuretics | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Annual Monitoring for Patients on Persistent Medications - Total | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Annual number of asthma patients ages 2 through 20 years old with 1 or more asthma-related emergency room visits | Management of Chronic Conditions | Alabama Medicaid | | X | | |
| Annual Pediatric hemoglobin A1C testing | Management of Chronic Conditions | NCQA | | X | | |
| Antidepressant Medication Management - Effective Acute Phase Treatment | Effectiveness of Care | NCQA/CAHPS | X | | X | |
| Antidepressant Medication Management - Effective Continuation Phase Treatment | Effectiveness of Care | NCQA/CAHPS | X | | X | |
| Appropriate Testing for Children With Pharyngitis | Effectiveness of Care | NCQA/CAHPS | X | X | | |
| Appropriate Treatment for Children With Upper Respiratory Infection | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Appropriate Use of Antenatal Steroids | Management of Acute Conditions | Providence St. Vincent Medical Center, TJC | | | X | |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Board Certification - Detail Table | Health Plan Descriptive | NCQA/CAHPS | | | | X |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| | Information | | | | | |
| Board Certification - Percent of Family Medicine Physicians | Health Plan Descriptive Information | NCQA/CAHPS | | | | X |
| Board Certification - Percent of Geriatricians | Health Plan Descriptive Information | NCQA/CAHPS | | | | X |
| Board Certification - Percent of Internal Medicine Physicians | Health Plan Descriptive Information | NCQA/CAHPS | | | | X |
| Board Certification - Percent of OB/GYNs | Health Plan Descriptive Information | NCQA/CAHPS | | | | X |
| Board Certification - Percent of Other Physician Specialists | Health Plan Descriptive Information | NCQA/CAHPS | | | | X |
| Board Certification - Percent of Pediatricians | Health Plan Descriptive Information | NCQA/CAHPS | | | | X |
| Breast Cancer Screening - Total | Effectiveness of Care | NCQA/CAHPS | X | | X | |
| Call Abandonment | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Call Answer Timeliness | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Care Transition - Transition Record Transmitted to Health Care Professional | Care Coordination | AMA-PCPI | | | X | |
| Cervical Cancer Screening | Effectiveness of Care | NCQA/CAHPS | X | | X | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Cesarean rate for nulliparous singleton vertex | Prevention and Health Promotion | California Maternal Quality Care Collaborative | | X | | |
| Child Survey - CCC Population: Access to Prescription Medicines Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Access to Specialized Services Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Coordination of Care Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Coordination of Care for Children With Chronic Conditions Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Customer Service Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Family Centered Care: Getting Needed Information Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Family Centered Care: Personal Doctor Who Knows Child Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Getting Care Quickly Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Getting Needed Care Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Health Promotion and Education Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: How Well Doctors Communicate Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Rating of All Health Care (8+9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Rating of All Health Care (9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Child Survey - CCC Population: Rating of Health Plan (8+9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Rating of Health Plan (9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Rating of Overall Health | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Rating of Personal Doctor (8+9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Rating of Personal Doctor (9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Rating of Specialist Seen Most often (8+9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Rating of Specialist Seen Most often (9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - CCC Population: Shared Decision Making Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Coordination of Care Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Customer Service Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Getting Care Quickly Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Getting Needed Care Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Health Promotion and Education Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: How Well Doctors Communicate Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Rating of All Health Care (8+9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Rating | Member | NCQA/CAHPS | | X | | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| of All Health Care (9+10) | Satisfaction | | | | | |
| Child Survey - General Population: Rating of Health Plan (8+9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Rating of Health Plan (9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Rating of Overall Health | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Rating of Personal Doctor (8+9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Rating of Personal Doctor (9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Rating of Specialist Seen Most often (8+9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Rating of Specialist Seen Most often (9+10) | Member Satisfaction | NCQA/CAHPS | | X | | |
| Child Survey - General Population: Shared Decision Making Composite | Member Satisfaction | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Combo 10 | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Combo 2 | Effectiveness of Care | NCQA/CAHPS | X | X | X | |
| Childhood Immunization Status - Combo 3 | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Combo 4 | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Combo 5 | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Combo 6 | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Combo 7 | Effectiveness of Care | NCQA/CAHPS | | X | | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Childhood Immunization Status - Combo 8 | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Combo 9 | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - DTaP | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Hepatitis A | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Hepatitis B | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - HiB | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Influenza | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - IPV | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - MMR | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Pneumococcal Conjugate | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - Rotavirus | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Childhood Immunization Status - VZV | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Children and Adolescents' Access To PCP (12-19 Yrs) | Access and Availability of Care | NCQA/CAHPS | | X | | |
| Children and Adolescents' Access To PCP (12-24 Months) | Access and Availability of Care | NCQA/CAHPS | | X | | |
| Children and Adolescents' Access To PCP (25 Months-6 Yrs) | Access and Availability of | NCQA/CAHPS | | X | | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| | Care | | | | | |
| Children and Adolescents' Access To PCP (7-11 Yrs) | Access and Availability of Care | NCQA/CAHPS | | X | | |
| Chlamydia Screening in Women - Total | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Chlamydia Screening in Women (Age 16-20) | Effectiveness of Care | NCQA/CAHPS | X | X | | |
| Chlamydia Screening in Women (Age 21-24) | Effectiveness of Care | NCQA/CAHPS | X | | X | |
| Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Chronic obstructive pulmonary disease (COPD) Admission Rate (PQI 05) | Prevention and Health Promotion | AHRQ | | | X | |
| Comprehensive Diabetes Care - Eye Exams | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Comprehensive Diabetes Care - HbA1c Control (<9%) | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Comprehensive Diabetes Care - HbA1c Testing | Effectiveness of Care | NCQA/CAHPS | X | | X | |
| Comprehensive Diabetes Care - LDL-C Screening | Effectiveness of Care | NCQA/CAHPS | X | | X | |
| Comprehensive Diabetes Care - Medical Attention for Nephropathy | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Congestive Heart Failure Admission Rate (PQI 08) | Prevention and Health Promotion | AHRQ | | | X | |
| Controlling High Blood Pressure - Total | Effectiveness of Care | NCQA/CAHPS | X | | X | |
| Customer Service Composite | Member Satisfaction | NCQA/CAHPS | X | | X | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Developmental Screening in the First Three Years of Life | Prevention and Health Promotion | NCQA and CAHMI | | X | | |
| Diabetes, short-term complications Admission Rate (PQI 01) | Prevention and Health Promotion | AHRQ | | | X | |
| Elective delivery prior to 39 completed weeks gestation | Management of Acute Conditions | HCA, TJC | | | X | |
| Frequency of Ongoing Prenatal Care (<21%) | Use of Services | NCQA/CAHPS | | X | | |
| Frequency of Ongoing Prenatal Care (>= 81%) | Use of Services | NCQA/CAHPS | | X | | |
| Frequency of Ongoing Prenatal Care (21-40%) | Use of Services | NCQA/CAHPS | | X | | |
| Frequency of Ongoing Prenatal Care (41-60%) | Use of Services | NCQA/CAHPS | | X | | |
| Frequency of Ongoing Prenatal Care (61-80%) | Use of Services | NCQA/CAHPS | | X | | |
| FU After Hospitalization For Mental Illness - 30 days | Effectiveness of Care | NCQA/CAHPS | | X | X | |
| FU After Hospitalization For Mental Illness - 7 days | Effectiveness of Care | NCQA/CAHPS | X | X | X | |
| FU Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase | Effectiveness of Care | NCQA/CAHPS | X | X | | |
| FU Care for Children Prescribed ADHD Medication - Initiation | Effectiveness of Care | NCQA/CAHPS | X | X | | |
| Getting Care Quickly Composite | Member Satisfaction | NCQA/CAHPS | X | | X | |
| Getting Needed Care Composite | Member Satisfaction | NCQA/CAHPS | X | | X | |
| HIV/AIDS Screening: Members at High Risk of HIV/AIDS | Prevention and Health Promotion | IMS Health | | | X | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| How Well Doctors Communicate Composite | Member Satisfaction | NCQA/CAHPS | X | | X | |
| Immunizations for Adolescents - Combination 1 | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Immunizations for Adolescents - Meningococcal | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Immunizations for Adolescents - Tdap/Td | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Detail Table | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (13-17 Yrs) | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (18+ Yrs) | Access and Availability of Care | NCQA/CAHPS | | | X | |
| Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement Total | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation (13-17 Yrs) | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation (18+ Yrs) | Access and Availability of Care | NCQA/CAHPS | | | X | |
| Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation Total | Access and Availability of Care | NCQA/CAHPS | | | | X |
| Inpatient Utilization - GH/Acute Care - Maternity ALOS | Use of Services | NCQA/CAHPS | | | | X |
| Inpatient Utilization - GH/Acute Care - Maternity Discharges/1000 | Use of Services | NCQA/CAHPS | | | | X |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Inpatient Utilization - GH/Acute Care - Total Inpatient ALOS | Use of Services | NCQA/CAHPS | | | | X |
| Inpatient Utilization - GH/Acute Care - Total Inpatient Discharges/1000 | Use of Services | NCQA/CAHPS | | | | X |
| Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit | Effectiveness of Care | NCQA/CAHPS | X | | X | |
| Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Medical Assistance with Smoking and Tobacco Use Cessation - Supplemental Data - % Current Smokers | Effectiveness of Care | NCQA/CAHPS | | | X | |
| Member BMI Average Value by Age Groups | Prevention and Health Promotion | NH DHHS | | | | X |
| Member Satisfaction - About You - Detail Table | Member Satisfaction | NCQA/CAHPS | | | X | |
| Member Satisfaction - Composite Scores - Detail Table | Member Satisfaction | NCQA/CAHPS | | | X | |
| Member Satisfaction - General - Detail Table | Member Satisfaction | NCQA/CAHPS | | X | X | |
| Member Satisfaction - Getting Health Care from Specialists - Detail Table | Member Satisfaction | NCQA/CAHPS | | | X | |
| Member Satisfaction - Your Health Care In the Last 6 Months - Detail Table | Member Satisfaction | NCQA/CAHPS | | | X | |
| Member Satisfaction - Your Health Plan - Detail Table | Member Satisfaction | NCQA/CAHPS | | | X | |
| Member Satisfaction - Your Personal Doctor - Detail Table | Member Satisfaction | NCQA/CAHPS | | | X | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Mental Health Utilization - % Members Receiving MH Services - Detail Table | Use of Services | NCQA/CAHPS | | | | X |
| Mental Health Utilization - % Members Receiving Services - Any | Use of Services | NCQA/CAHPS | | | | X |
| Mental Health Utilization - % Members Receiving Services - Inpatient | Use of Services | NCQA/CAHPS | | | | X |
| Mental Health Utilization - % Members Receiving Services - Intensive Outpatient and Partial Hospitalization | Use of Services | NCQA/CAHPS | | | | X |
| Mental Health Utilization - % Members Receiving Services - Outpatient and ED | Use of Services | NCQA/CAHPS | | | | X |
| Otitis media with effusion (OME) – avoidance of inappropriate use of systemic antimicrobials in children – ages 2 through 12 | Management of Acute Conditions | AMA | | X | | |
| Pediatric central-line associated blood stream infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit | Management of Acute Conditions | CDC | | X | | |
| Percent of live births weighing less than 2,500 grams | Prevention and Health Promotion | CDC | | X | | |
| Plan All-Cause Readmissions | Use of Services | NCQA/CAHPS | | | X | |
| Prenatal and Postpartum Care - Postpartum Care | Access and Availability of Care | NCQA/CAHPS | X | | X | |
| Prenatal and Postpartum Care - Timeliness of Prenatal Care | Access and Availability of Care | NCQA/CAHPS | X | X | X | |
| Rating of All Health Care (8+9+10) | Member Satisfaction | NCQA/CAHPS | X | | X | |
| Rating of All Health Care (9+10) | Member Satisfaction | NCQA/CAHPS | X | | X | |
| Rating of Health Plan (8+9+10) | Member Satisfaction | NCQA/CAHPS | X | | X | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Rating of Health Plan (9+10) | Member Satisfaction | NCQA/CAHPS | X | | X | |
| Rating of Personal Doctor (8+9+10) | Member Satisfaction | NCQA/CAHPS | X | | X | |
| Rating of Personal Doctor (9+10) | Member Satisfaction | NCQA/CAHPS | X | | X | |
| Rating of Specialist Seen Most often (8+9+10) | Member Satisfaction | NCQA/CAHPS | X | | X | |
| Rating of Specialist Seen Most often (9+10) | Member Satisfaction | NCQA/CAHPS | X | | X | |
| Screening for Clinical Depression and Follow-Up Plan | Prevention and Health Promotion | CMS | | | X | |
| Shared Decision Making Composite | Member Satisfaction | NCQA/CAHPS | | | X | |
| Smoking Cessation Among Pregnant Women | Prevention and Health Promotion | NH DHHS | | | | X |
| Survey Item: Did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often did the written materials or the Internet provide the information you needed about how your health plan works? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often did you and a doctor or other health provider talk about specific things you could do to prevent illness? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often did your health plan's customer service give you the information or help you needed? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often did your health plan's customer service staff treat you with courtesy and respect? | Member Satisfaction | NCQA/CAHPS | | | X | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Survey Item: How often did your personal doctor explain things in a way that was easy to understand? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often did your personal doctor listen carefully to you? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often did your personal doctor show respect for what you had to say? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often did your personal doctor spend enough time with you? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often was it easy to get appointments with specialists? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often was it easy to get the care, tests, or treatment you thought you needed through your health plan? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: How often were the forms from your health plan easy to fill out? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: In general, how would you rate your overall health? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: Not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: When there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice was best for you? | Member Satisfaction | NCQA/CAHPS | | | X | |
| Survey Item: When you needed care right away, how often did you get care as soon as | Member Satisfaction | NCQA/CAHPS | | | X | |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| you thought you needed? | | | | | | |
| Use of Appropriate Medications for People with Asthma - Total | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Use of Appropriate Medications for People with Asthma (12-50) | Effectiveness of Care | NCQA/CAHPS | | | | X |
| Use of Appropriate Medications for People with Asthma (5-11) | Effectiveness of Care | NCQA/CAHPS | | | | X |
| Use of Imaging Studies for Low Back Pain | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | Effectiveness of Care | NCQA/CAHPS | X | | | |
| Weeks of Pregnancy at Time of Enrollment - Detail Table | Health Plan Descriptive Information | NCQA/CAHPS | | | | X |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17 years) | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11 years) | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total) | Effectiveness of Care | NCQA/CAHPS | | X | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 years) | Effectiveness of Care | NCQA/CAHPS | | | | X |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 years) | Effectiveness of Care | NCQA/CAHPS | | | | X |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total) | Effectiveness of Care | NCQA/CAHPS | | | | X |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 years) | Effectiveness of Care | NCQA/CAHPS | | | | X |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 years) | Effectiveness of Care | NCQA/CAHPS | | | | X |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total) | Effectiveness of Care | NCQA/CAHPS | | | | X |
| Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life | Use of Services | NCQA/CAHPS | | X | | |
| Well-Child Visits in the first 15 Months of Life (0 visits) | Use of Services | NCQA/CAHPS | | X | | |
| Well-Child Visits in the first 15 Months of Life (1 visit) | Use of Services | NCQA/CAHPS | | X | | |
| Well-Child Visits in the first 15 Months of Life (2 visits) | Use of Services | NCQA/CAHPS | | X | | |
| Well-Child Visits in the first 15 Months of Life (3 visits) | Use of Services | NCQA/CAHPS | | X | | |
| Well-Child Visits in the first 15 Months of Life (4 visits) | Use of Services | NCQA/CAHPS | | X | | |
| Well-Child Visits in the first 15 Months of Life (5 visits) | Use of Services | NCQA/CAHPS | | X | | |
| Well-Child Visits in the first 15 Months of Life (6 or more visits) | Use of Services | NCQA/CAHPS | | X | | |
| Behavioral Health: NH Public Mental Health Consumer Survey, Data | Member Satisfaction | SAMHSA | | | | X |

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| Measure | Domain | Source | Current NCQA Medicaid Accreditation | Current CMS Child Quality | Current CMS Adult Quality | Additional State Required Measures |
|---|---|---|---|---|---|---|
| Infrastructure Grant Mental Health Consumer Survey or Mental Health Sickness Indicator Profile (MHSIP) Consumer Survey | | | | | | |
| Developmental Services: National Care Indicators Adult Consumer, Adult Family, Family Guardian, and Child Family Surveys. | Member Satisfaction | National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). | | | | X |
| Elderly and Adult Services: CMS Participant Experience Survey | Member Satisfaction | CMS | | | X | |

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## Appendix E: NH Medicaid Care Management Program Encounter, Member and Provider Data Detail

Data detail as presented in the NH Medicaid Care Management Contract and as referenced. *Last Updated 7.2.12. Consult with the Department for any recent updates prior to use.*

| MCO Encounter, Member, and Provider Data Sets Data Elements | Medical Encounter | Pharmacy Encounter | Member |
|---|---|---|---|
| Allowed amount | x | x | |
| Billed/Charge Amount | x | x | |
| Billing Provider City Name | x | x | |
| Billing Provider Country Name | x | x | |
| Billing Provider Location City Name | x | x | |
| Billing Provider Location State or Province | x | x | |
| Billing Provider Location Street Address | x | x | |
| Billing Provider Location ZIP Code | x | x | |
| Billing Provider Medicaid ID | x | x | |
| Billing Provider Name | x | x | |
| Billing Provider NPI | x | x | |
| Billing Provider Payer ID | x | x | |
| Billing Provider Specialty | x | x | |
| Billing Provider State or Province | x | x | |
| Billing Provider Street Address | x | x | |
| Billing Provider Type (e.g., hospital, optometrist) | x | x | |
| Billing Provider ZIP Code | x | x | |
| Category/Type of Service (e.g., 'Physician') universal across claim types to be defined in conjunction with DHHS, standard across MCOs) | x | x | |
| Charge Amount | x | x | |
| Claim Adjudication Date | x | x | |
| Claim ID | x | x | |

| MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements | Medical Encounter | Pharmacy Encounter | Member |
|---|---|---|---|
| Claim Line Number | x | x | |
| Claim Paid Date | x | x | |
| Claim Transaction Status (e.g., paid, denied) | x | x | |
| Claim Transaction Type (e.g., adjusted claim, void) | x | x | |
| Claim Type (e.g., drug, medical) | x | x | |
| Claim Version | x | x | |
| Co-pay Amount | x | x | |
| Date Claim Received | x | x | |
| Date of Service – From | x | x | |
| Date of Service – Through | x | x | |
| Date Service Approved | x | x | |
| Diagnosis Codes Principal and Other - MCO to Provide All Submitted by Providers | x | | |
| Discharge Date | x | | |
| Dual Medicare Status at Service Date of Claim | x | x | |
| E-Code | x | | |
| EOB Codes | x | | |
| Facility Type - Professional | x | | |
| Institutional - Admission Date | x | | |
| Institutional - Admission Hour | x | | |
| Institutional - Admission Source | x | | |
| Institutional - Admission Type | x | | |
| Institutional - Admitting Diagnosis | x | | |
| Institutional - Covered Days | x | | |
| Institutional - Days | x | | |

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| MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements | Medical Encounter | Pharmacy Encounter | Member |
|---|---|---|---|
| Institutional - Discharge Hour | x | | |
| Institutional - Discharge Status | x | | |
| Institutional - Inpatient - Present on Admission Codes for All Diagnosis Codes as Specified by DHHS | x | | |
| Institutional - Inpatient DRG (if DRG payment system is used) | x | | |
| Institutional - Inpatient DRG allowed amount (if DRG payment system is used) | x | | |
| Institutional - Inpatient DRG outlier amount (if DRG payment system is used) | x | | |
| Institutional - Inpatient DRG outlier days (if DRG payment system is used) | x | | |
| Institutional - Inpatient DRG Version (if DRG payment system is used) | x | | |
| Institutional - Inpatient DRG Version (if used) | x | | |
| Institutional - Occurrence Code Values/Dates - MCO to Provide All Submitted by Providers | x | | |
| Institutional - Occurrence Codes - MCO to Provide All Submitted by Providers | x | | |
| Institutional - Revenue Code | x | | |
| Institutional - Type of Bill | x | | |
| Institutional Inpatient Procedure Codes (ICD) - MCO to Provide All Submitted by Providers | x | | |
| Institutional Paid Amount - Detail (where applicable) | x | x | |
| MCO Assigned Provider ID | x | x | |
| MCO Group ID Number | x | x | x |
| MCO ID | x | x | x |
| MCO Internal Member ID | x | x | x |
| Medicaid Eligibility Category at Service Date on Claim | x | x | |
| Medicaid Special Eligibility Category at Service Date on Claim (e.g., nursing home, waiver program) | x | x | |

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| MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements | Medical Encounter | Pharmacy Encounter | Member |
|---|---|---|---|
| Medical Claim Drug Codes (e.g., J codes) | x | | |
| Member Address | x | x | x |
| Member Age at Time of Claim Using Last Date of Service | x | x | |
| Member Bureau of Behavioral Health Eligibility Status | | | x |
| Member City | x | x | x |
| Member County | | | x |
| Member Date of Birth | x | x | x |
| Member Date of Death | | | x |
| Member Dual Medicare Status | | | x |
| Member Gender | x | x | x |
| Member Lock-In Dates | | | x |
| Member Lock-In Indicator | | | x |
| Member Lock-In Pharmacy/Provider | | | x |
| Member Medicaid Eligibility Category | | | x |
| Member Medicaid Special Eligibility Category (e.g., nursing home, waiver program) | | | x |
| Member Name | x | x | x |
| Member Rate Cell | | | x |
| Member Risk Score/Status | | | x |
| Member Risk Status Percentile Rank | | | x |
| Member SSN | | | x |
| Member State | x | x | x |
| Member Year and Month | | | x |
| Member Zip Code | x | x | x |
| NH Medicaid Member ID | x | x | x |
| Outpatient Hospital Payment Group (if used) | x | | |

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| MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements | Medical Encounter | Pharmacy Encounter | Member |
|---|---|---|---|
| Outpatient Hospital Payment Grouper Used (if used) | x | | |
| Outpatient Hospital Payment Grouper Version (if used) | x | | |
| Paid Amount | x | x | |
| Pharmacy Basis of Provider Reimbursement on the Paid Claim | | x | |
| Pharmacy Compound Drug Indicator | | x | |
| Pharmacy Days Supply | | x | |
| Pharmacy Dispensed as Written Indicator | | x | |
| Pharmacy Dispensing Fee | | x | |
| Pharmacy Drug Name | | x | |
| Pharmacy Drug NDC | | x | |
| Pharmacy Fill Number | | x | |
| Pharmacy Generic Drug Indicator | | x | |
| Pharmacy Ingredient Cost | | x | |
| Pharmacy Location City Name | | x | |
| Pharmacy Location State or Province | | x | |
| Pharmacy Location ZIP Code | | x | |
| Pharmacy Metric Units | | x | |
| Pharmacy Name | | x | |
| Pharmacy NH Medicaid Pharmacy Provider ID | | x | |
| Pharmacy Postage Amount | | x | |
| Pharmacy Prescribing Provider DEA Number | | x | |
| Pharmacy Prescribing Provider MCO ID | | x | |
| Pharmacy Prescribing Provider NPI | | x | |
| Pharmacy Prescription Number | | x | |
| Pharmacy Tax ID | | x | |

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| MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements | Medical Encounter | Pharmacy Encounter | Member |
|---|---|---|---|
| Place of Service | x | x | |
| Prepaid Amount/Fee Schedule Equivalent (if provider being paid on capitated basis) | x | x | |
| Primary Care Provider Assigned From Date | | | x |
| Primary Care Provider Assigned To Date | | | x |
| Primary Care Provider Clinic/Business Name | | | x |
| Primary Care Provider Location City Name | | | x |
| Primary Care Provider Location State or Province | | | x |
| Primary Care Provider Location Street address | | | x |
| Primary Care Provider Location ZIP Code | | | x |
| Primary Care Provider Medicaid ID | | | x |
| Primary Care Provider Name | | | x |
| Primary Care Provider NPI | | | x |
| Primary Care Provider Payer ID | | | x |
| Primary Care Provider Specialty | | | x |
| Primary Care Provider Tax ID | | | x |
| Primary Care Provider Type (e.g., Physician, APRN) | | | x |
| Prior Authorization Number | x | x | |
| Procedure Codes (HCPCS/CPT) - MCO to Provide All Submitted by Providers as Specified by DHHS | x | | |
| Procedure Modifier Codes and Description – MCO to Provide All Submitted by Providers as Specified by DHHS | x | | |
| Quantity/Units Billed | x | | |
| Quantity/Units Paid | x | | |
| Referring Provider Name | x | | |
| Referring Provider NPI | x | | |
| Referring Provider Payer ID | x | | |

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| MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements | Medical Encounter | Pharmacy Encounter | Member |
|---|---|---|---|
| Rendering/Service Provider Country Name | x | x | |
| Rendering/Service Provider Name | x | x | |
| Rendering/Service Provider NPI | x | x | |
| Rendering/Service Provider Payer ID | x | x | |
| Rendering/Service Provider Rendering/Service Location City Name | x | x | |
| Rendering/Service Provider Rendering/Service Location State or Province | x | x | |
| Rendering/Service Provider Rendering/Service Location ZIP Code | x | x | |
| Rendering/Service Provider Specialty | x | x | |
| Rendering/Service Provider Street Address | x | x | |
| Rendering/Service Provider Tax ID | x | x | |
| Rendering/Service Provider Type (e.g., physician, APRN) | x | x | |
| TPL Medicare Allowed Amount | x | x | |
| TPL Medicare Coinsurance Amount | x | x | |
| TPL Medicare Deductible Amount | x | x | |
| TPL Medicare Paid Amount | x | x | |
| TPL Medicare Paid Date | x | x | |
| TPL Other Payers Allowed Amount - MCO to Supply All Other Payer Information | x | x | |
| TPL Other Payers Coinsurance Amount - MCO to Supply All Other Payer Information | x | x | |
| TPL Other Payers Deductible Amount - MCO to Supply All Other Payer Information | x | x | |
| TPL Other Payers Name - MCO to Supply All Other Payer Information | x | x | |
| TPL Other Payers Paid Amount - MCO to Supply All Other Payer Information | x | x | |
| TPL Other Payers Paid Date - MCO to Supply All Other Payer Information | x | x | |
| Note: Medical and Pharmacy are transaction specific encounter data sets; Member is a month specific file, and Provider file must represent present and historical provider network. | | | |

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| MCO Coordination of Benefits Data Set Data Elements (From NH Medicaid Care Management Contract) |
|---|
| Medicaid Member Name |
| NH Medicaid Member ID |
| Insurance Carrier, PBM, or Benefit Administrator ID |
| Insurance Carrier, PBM, or Benefit Administrator Name |
| Date of Service |
| Claim ID (transaction code number) |
| Date billed to the insurance carrier, PBM, or benefit administrator |
| Amount billed |
| Amount recovered |
| Denial reason code |
| Denial reason description |
| Performing provider |
| Note: COB is a transaction specific data set submitted monthly in a delimited flat text file. |

| MCO to NH DHHS Provider File Data Elements (Version 0.2) |
|---|
| MCO ID (unique ID for the MCO that spans all MCO submitted data) |
| MCO Assigned Provider ID |
| MCO Group ID Number (if used) |
| Provider Certification Data (licensure, provider residency/fellowship, date and specialty of Board Certification status) |
| Provider In-Network Indicator |
| Provider Multiple Service Location Indicator |
| Provider Location Type (e.g., border, in-state, out-of state) |
| Provider ID NH Medicaid Assigned |
| Provider ID MCO Assigned |
| Provider NPI |
| Provider Taxonomy |
| Provider SSN/TIN |

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| MCO to NH DHHS Provider File Data Elements (Version 0.2) |
|---|
| Provider DEA/CDS |
| Provider Organization or Individual? |
| Provider Organization Name (if non-person provider) |
| Provider Individual Last Name (blank if non-person provider) |
| Provider Individual First Name (blank if non-person provider) |
| Provider Individual Middle Name (blank if non-person provider) |
| Provider Individual Suffix (blank if non-person provider) |
| Provider Individual Degree (e.g., MD, CRNA) (blank if non-person provider) |
| Provider Specialty 1 (Primary) |
| Provider Specialty 2 |
| Provider Specialty 3 |
| Provider Specialty 4 |
| Provider Associated Organization Name(s) |
| Provider Service Location(s) Street Address 1 |
| Provider Service Location(s) Street Address 2 |
| Provider Service Location(s) City Name |
| Provider Service Location(s) State or Province |
| Provider Service Location(s) ZIP Code |
| Provider Service Location(s) Country Name |
| Provider Service Location(s) County Name |
| Provider Service Location(s) Telephone Number |
| Provider Service Location(s) Latitude |
| Provider Service Location(s) Longitude |
| Provider Type (e.g., physician, APRN, group) |
| Provider Listed as Primary Care Provider in MCO Directory Flag |
| Number of Openings in Primary Care Provider Panel |

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| **MCO to NH DHHS Provider File Data Elements (Version 0.2)** |
|---|
| Provider Appears in MCO Directory Flag |
| Non-primary care Practice: Open vs. Closed |
| Date Enrolled by MCO |
| Date Terminated by MCO |
| MCO Termination Reason |
| Provider Status (e.g., active, inactive, terminated, dead, etc.) |
| Provider Rendering of Service, Billing, or Both? |
| Provider Association to Organization(s) |
| Organizational or individual provider type |
| Medical/Health Home: yes vs. no |
| *Credentialing related* |
| Site visit date |
| Physical Accessibility and appearance/ADA compliant |
| Medical records: paper vs. electronic |
| Meeting meaningful use criteria: met vs. not met |
| Review by the appropriate accreditation organization |
| Medicare Provider Flag |
| Credentialed Medicaid Provider In Other State; indicate state |
| Active license; NH, other state |
| Malpractice Insurance: yes vs. no |
| Education and Work history validation: yes vs. no |
| National Practitioner Data Bank |
| License or Workplace Limits, Discipline, Loss of Privilege: Flag |
| License or Workplace Limits, Discipline, Loss of Privilege: Detail |
| Felony Conviction: yes vs. no |
| OIG Exclusion: yes vs. no |

| **MCO to NH DHHS Provider File Data Elements (Version 0.2)** |
|---|
| Tax Delinquency: yes vs. no |
| Criminal Background Check: criminal vs. non |
| Fingerprinting Required: yes vs. no |
| *Additional Technical Requirements (Solutions Pending)* |
| File(s) must represent present and historical provider network (i.e., changes in any data) |
| File(s) must allow individuals to be associated with multiple groups |
| File(s) must allow individuals to be associated with multiple service locations |

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## Appendix F: NH Medicaid Care Management Contract Compliance with CMS Clinical Standards and Guidelines

The following table meets the requirement of 42 CFR 438.204(a) by itemizes the required components and identifies the reference for the contract provisions that incorporate the standards of 42 CFR 438 Subpart D in the NH Medicaid Care Management contract.

| 42 CFR Subpart D: Reference and Summarized Content | Contract Provision (NH Medicaid Care Management Contract Section Reference) |
|---|---|
| 438.204 - Elements of state quality strategy | |
| • The State and the MCOs must assess the quality and appropriateness of care and services to all enrollees and individuals with special health care needs | • 20.4.2, 20.1.3, 20.1.13 |
| • The State and the MCOs must identify race, ethnicity and primary language spoken. | • 16.1.5, 16.1.13 |
| • The State must regular monitor MCO compliance with quality standards, including: | |
| ◦ National measures, | • 20.5 |
| ◦ Annual, external independent review, | • 18.1.4 |
| ◦ The State's information systems, and | • 22 |
| ◦ Standards at least as stringent as those in the Federal regulations, for access to care, structure and operation, and quality measurement and improvement. | • 21.1.1, 26 |
| **Access Standards** | |
| 438.206 - Availability of services | |
| • The MCO must maintain and monitor a delivery network supported by written agreements and is sufficient to provide adequate access to services covered under the contract to the population to be enrolled. | • 19.1.1 |
| • The MCO must provide female enrollees direct access to women's health specialists. | • 18.4.1 |
| • The MCO must provide for a second opinion. | • 18.7 |
| • The MCO must provide out of network services when not available in network. | • 18.6 |
| • The MCO must provide assurance that the costs to enrollees out-of-network are no greater than in-network. | • 18.6.3 |
| • The MCO must demonstrate that providers are credentialed. | • 19.3 |
| • The MCO must demonstrate that both the MCO and its providers furnish services with timely access and cultural competence. | • 19.1.4; 16.1.2 |
| 438.207 - Assurances of adequate capacity and services | |
| • The MCO must provide documentation that demonstrates it has capacity to serve the expected enrollment, submit the documentation in a format specified by the State at time of contracting and any time there is a significant change. | • 19.1.1, 32.7.1 |
| 438.208 - Coordination and continuity of care | |
| • The MCOs must implement procedures to deliver primary care and coordinate health care services to enrollees. | • 10.1; 10.2; 10.3; 10.9 |

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|---|---|
| • The State must implement procedures to identify persons with special health care needs.<br>For individuals with special health care needs:<br>• The MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions and developing a treatment plan.<br>• The MCOs must have a mechanism to allow persons identified with special health care needs to access specialty care directly (standing referral). | • 10.8.2<br>• 10.8<br>• 10.8.1 |
| 438.210 - Coverage and authorization of services<br>• The MCOs must define the amount, duration and scope of services provided.<br>• The MCOs must specify "medically necessary services."<br>• The MCOs must have a service authorization process. | • 8.2.1, 8.2.4, 8.2.5, 21.1.1<br>• 21.2<br>• 21 |
| **Structure and Operation Standards** | |
| 438.214 – Provider selection<br>• The MCOs must implement written policies and procedures for selection and retention of providers.<br>• The State must establish a uniform credentialing and recredentialing policy. MCO must follow a documented process for credentialing and recredentialing.<br>• The MCOs cannot discriminate against providers that serve high-risk populations.<br>• The MCOs must exclude providers who have been excluded from participation in Federal health care programs. | • 19.3<br>• 19.3<br>• 19.1.2, 32.3.1<br>• 19.3.8 |
| 438.218 - Information Requirements<br>• The State and MCOs must meet the requirements of 42CFR438.10 | • 14.2.3, 15.1.2, 15.1.12 |
| 438.224 - Confidentiality<br>• The MCOs must comply with all state and federal confidentiality rules. | • 28.1.4, 28.1.6, 21.1.6, 22.5.11.9, 22.5.17.1, 32.4.6 |
| 438.226 - Enrollment and disenrollment<br>• The MCOs must comply with the enrollment and disenrollment standards in 42CFR438.56. | • 14 |
| 438.228 - Grievance systems<br>• The MCOs must comply with grievance system requirements in 42CFR438 Subpart F.<br>• The State will conduct random reviews of enrollee notification through its EQRO. | • 17<br>• 20.3, 20.3-Included into EQRO Scope of Work in development |

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|---|---|
| 438.230 - Subcontractual relationships and delegation | |
| • The MCOs are accountable for any functions or responsibilities that it delegates. | • 5.1 |
| • The MCOs must have a written agreement that regularly monitors and specifies the activities and report responsibilities that are delegated and specifies the revocation of the agreement if the subcontractor's performance is inadequate. | • 5.3 |
| **Measurement and Improvement Standards** | |
| 438.236 - Practice guidelines | |
| • The MCOs must adopt practice guidelines that are based on valid and reliable evidence or a consensus of health care professionals in the field; consider the needs of the population, are adopted in consultation with health care professionals, and are reviewed and updated periodically | • 20.7 |
| • The MCOs must disseminate guidelines. | • 20.2.3 |
| • The MCOs must apply guidelines to coverage decisions. | • 20.2.4 |
| 438.240 - Quality assessment and performance improvement (QAPI) program | |
| • Each MCO must have an ongoing QAPI program. | • 20.1.3 |
| • The MCOs conduct general performance measurement, including the detection of both under-utilization and over-utilization and an assessment of the quality and appropriateness of care furnished to enrollees with special health care needs. | • 20.1.3, 20.1.4.4, 20.1.5, 20.1.13 |
| • The MCOs must measure and report to the State its performance using standard performance measures required by the state. Submit data specified by the State to measure performance. | • 20.1.6, 20.5 |
| • The MCOs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Projects should be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects should include: Measurement of performance using objective quality indicators, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the intervention, planning and initiation of activities for increasing or sustaining improvement. Each plan must report to the State the results of each project. | • 20.1.11 |
| • The State must review at least annually, the impact and effectiveness of the each program. | • 20.4, 20.1.7, 20.1.4, 20.3-Included into EQRO Scope of Work in development |

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| 438.242 - Health information systems<br>• The MCOs must have a system in place that collects, analyzes, integrates, and reports data and supports the plan's compliance with the quality requirements.<br>• The MCOs collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system.<br>• The MCOs must ensure that data from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, collecting service information in standardized formats, make all data available to the State and CMS.<br>• Make the data available to the State and CMS. | • 22<br>• 22.5.3<br>• 22.5.10.5, 22.5.10.6, 23.2, 23.2.24, 32.7.2, 32.7.5<br>• 23.1.1, 22.5.10, 22.5.15, 32.6.2 |

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**Appendix G: NH Medicaid Care Management Program Routine Quality Reports**

General reporting requirements:

Unless otherwise specified within the NH Medicaid contract, the following standard reporting requirements apply. The MCOs must hold subcontractors accountable to the Quality Strategy requirements for any data and reporting. *Last Updated 7.2.12. Consult with the Department for any recent updates prior to use.*

Distribution and Presentation:

- Daily reports must be available at 8:00 am Eastern Time, Tuesday through Sunday.
- Monthly reports must be available no later than the 10th calendar day of each month for the previous month's data.
- Quarterly reports must be available no later than the 10th calendar day following the end of the quarter.
- Annual reports must be available no later than the 30th calendar day following the end of the defined year (e.g. fiscal, calendar, quality, etc).
- Periodic reports must be aggregated into a consolidated report, i.e. all monthly reports distributed as a single monthly report, and presented to the DHHS account manager and the DHHS program subject matter contact.
- All reports must be provided in an electronic file that allows text and visual displays of information to be exported, edited and used by DHHS (e.g. graphs in PowerPoint, executive summaries exported into other documents, etc.)

Analysis:

- All reports should include outcome measures to the greatest extent possible in addition to structure and process measures,
- All reports should include quantitative assessments to the greatest extent possible in addition to any qualitative assessments,
- All reports should incorporate appropriate comparators which must be approved by DHHS prior to use, and
- All reports should include sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.

Baselines:

- Baselines for cost savings where necessary shall e the twelve (12) month period prior to the Agreement Year, or the twelve (12) month period prior to the new program initiative, but at no time may be greater than two (2) years prior to the program period being evaluated.
- Innovations in place for greater than twenty-four (24) months will have to baseline reset so that a new baseline is established for the second and for each subsequent twenty-four (24) month period of the initiative.

n.b. Reports noted are exclusive of the plans and reports exclusive to the initial implementation of the NH Medicaid Care Management program.

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| Program Management and Planning: Program Management | Description of MCO program management and measurement including, but not limited to,<br>• A framework of processes to be used by the MCO and NH DHHS for managing and monitoring all aspects of the Care Management Program,<br>• Sufficient detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities, and<br>• Documentation of approval change history. | Annually | 2; 7.4.1 |
| Program Management and Planning: Communications | Description of MCO communications, including, but not limited to,<br>• The objectives, tasks, activities, time allocation, deliverables, dependencies and responsible party regarding the implementation and operations of the Care Management Program,<br>• The audience, purpose of the communication, paths of communication, means of communication, time line and evaluation of effectiveness of messages, and<br>• Documentation of approvals and change history. | Annually | 2; 7.4.2 |
| Program Management and Planning: Emergency Response Plan | Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs, including, but not limited to, specific pandemic and natural disaster preparedness. | Annually | 7.5 |
| Payment Reform Initiative | Overview of the MCO Payment Reform Initiative, including, but not limited to:<br>• Brief description of the Payment Reform Initiative inclusive of program goals, member health outcomes, and providers affected,<br>• Executive summary of annual findings,<br>• Incorporating and use of sufficiently detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, successes and opportunities,<br>• Year I shall address implementation of the Payment Reform Initiative inclusive of measurable implementation milestones, subsequent years shall address program results,<br>• Comment and compliance with the requirements set forth in Section 9.1.5, including, but not limited to, rates paid, federal regulation, requests for program | Annually | 9 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | information,<br>• For each provider group within the program: covered services not furnished by provider groups with the program, the type of incentive arrangement, the percentage of withhold or bonus, panel size and methodology used for assignment or pooling, adequate coverage of stop loss coverage if at financial risk | | |
| MCO Payment Reform Plan Implementation Milestones | Describe the progress made toward implementation of the MCO Payment Reform Plan, including, but not limited to:<br>• Brief description of the payment reform initiatives inclusive of program goals, member health outcomes, and providers affected,<br>• Executive summary of progress toward implementation, any correction or challenges being encounter and how those challenges are being addressed,<br>• Sufficient detail to accurately assess progress toward each implementation goal, an analysis of any challenges or corrective action and how those challenges or changes will be addressed. | Quarterly, Annually | 9.1.4 |
| Care Management: Care Management Plan | Overview of the MCO comprehensive care management and as assessment of MCO care management, with comprehensive care coordination across its health plan, other payers, fee-for-service Medicaid, community services and other health and social service providers; promoting and assuring service accessibility; centered on individual member and care giver needs with member and family involvement; community centered; culturally appropriate care; specifically including, but not limited to:<br>• Care coordination,<br>• Non-emergent transport,<br>• Wellness and prevention,<br>• Member health education,<br>• Complex care member management,<br>• Members with special needs.<br><br>The Care Management Plan must include all of the elements addressed in each sub-section of Section 10.<br><br>For any delegated tasks, the MCO must provide the reason for delegation, the tasks being delegated, how the determination and assurance of quality operations and/or services was made. Any delegated activities must be comprehensively compliant with the reporting in the Quality Strategy and specifically with | Annually | 10 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | the Care Management Plan and reporting.<br><br>For each Agreement year after Year I, the MCO shall include in the Care Management Plan a quantitative, data driven and, to the extent possible, statistically valid assessment of the prior years successes and new opportunities to improve the Care Management program, member health outcomes, and member and family experience of care. Any measures not otherwise specified in the NH Medicaid MCO contract and used for Care Management assessment must have prior approved from DHHS and should draw from national quality measurement experience to the greatest extent possible. | | |
| Care Management: Systems of Care for Children | Report on activities that ensure member and family involvement in the development of a system of care for children with serious emotional disturbance. | Quarterly, Annually | 10.1.3 |
| Care Management: NEMT | Report on Non-Emergent Transportation (NEMT) to include, but not be limited to:<br>• Types of NEMT used,<br>• Number of members transported via NEMT, and<br>• Requested, completed and not provided when requested NEMT events. | Monthly | 10.4 |
| EPSDT Services: EPSDT Plan | The MCO Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) Plan. | Annually | 11 |
| Behavioral Health: Community Based Services Utilization | Report by region of the ratio of community based services to office-based services. | Biannually | 12.1.5.7 |
| Behavioral Health: CANS and ANSA Training and Utilization | Report on use of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA) by community mental health workers to include:<br>• Number of community mental health providers needing training,<br>• Number of providers trained and certified,<br>• Number of members receiving community mental health services,<br>• Number of member receiving either CANS or ANSA each quarter, and<br>• An assessment of Training and Utilization successes and opportunities with comment on opportunity improvement*. | Quarterly | 12.1.6 |
| Behavioral Health: Olmstead Plan Support | Report on the MCO activities related to the NH Olmstead Plan, "Addressing the Critical Mental Health Needs of NH Citizens: A Strategy for Resolution" including at minimum,<br>• An assessment of the availability, use and need for Assertive Community Treatment Teams, by region and statewide,<br>• Community residential capacity, by region and statewide, and | Annually | 12.1.8 |

| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | • Community tenure strategies to address admissions and readmissions at New Hampshire hospital, for children and adults. | | |
| Behavioral Health: Mental Health Service Providers Training Plan and Reporting | The MCO shall submit a plan for and report on how the MCO shall support the community mental health system hire, train and retain qualified staff, including, but not limited to:<br>• Type of training provided with participant list, summary of activity and evaluation of the training,<br>• How evidence based practices are sustained and/or expanded upon, including specific comment on each of the practices listed in 12.1.10.3,<br>• Suicide prevention and post-intervention training, and<br>• An assessment of training strengths and opportunities with how those opportunities will address in the subsequent Agreement Year.<br><br>For any delegated tasks, the MCO must provide the reason for delegation, the tasks being delegated, how the determination and assurance of quality operations and/or services was made. Any delegated activities must be comprehensively compliant with the reporting in the Quality Strategy and specifically with the Mental Health Service Providers Training Plan and reporting. | Annually | 12.1.10 |
| Behavioral Health: Consent for Primary Care – Behavioral Health Coordination | The MCO shall report on Consent for Primary Care – Behavioral Health Coordination, including, but not limited to:<br>• All instances in which consent was not given, and<br>• If possible the reason for refusal of consent,<br>• A plan to improve the likelihood of consent for the subsequent Agreement year, subject to review and approval from DHHS*. | Annually | 12.2.12 |
| Behavioral Health: Homelessness | The MCO shall report on homelessness, specifically discharge from New Hampshire Hospital to including, but not limited to:<br>• Number of discharges to homeless shelters and homelessness,<br>• The reasons for discharge to the shelters or homelessness,<br>• The efforts made by the MCO to arrange appropriate placements, and<br>• A plan to decrease the likelihood of discharge to a shelter or homelessness for the subsequent Agreement year, subject to prior review and approval from DHHS. | Annually | 12.1.15.1 |
| Behavioral Health: | The MCO shall submit a plan for and report on how | Annually for | 12.1.16 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| Reductions in Readmission Plan | the MCO shall reduce readmission to New Hampshire Hospital, including, but not limited to:<br>• The development of a discharge plan,<br>• Member receipt of the discharge plan,<br>• Contact with the member within 3 calendar days of discharge,<br>• A follow up appointment within 7 calendar days,<br>• An assessment of the barriers to discharge and a plan to reduce the barriers and improve community tenure in the subsequent Agreement year, subject to prior review and approval from DHHS. | Plan, Quarterly Readmissions Reporting | |
| Pharmacy Management: Service Operations | The MCO shall report on pharmacy services operations standards and must maintain response times of:<br>• 95% of electronic systems transactions less than one (1) second,<br>• 24 hours to a request for prior authorization,<br>• Call Center customer services (e.g. inbound calls received, speed to answer, hold times, total call time, calls abandoned, etc.). | Quarterly | 13.1.8; 13.1.9 |
| Pharmacy Management: Utilization Controls | The MCO shall report on pharmacy utilization controls including but not limited to:<br>• Prior authorizations, number, approved, denied, partially approved,<br>• Generic utilization, including, but not limited to the percentage of generics/ all drugs, the percentage of generics / all drugs for which a generic is available and the brand is not required by the NH PDL, percentage of generics/ all drugs for which a generic is available,<br>• Mail order pharmacy use if any,<br>• Rankings by various parameters (e.g. claim count, payment amount, average payment) for, but not limited to: Top X member, Top X drug, Top X therapeutic class use, Top X ingredient, Top X prescriber, Top X pharmacy,<br>• PDL utilization by various parameters (e.g. member, prescribers, therapeutic class, etc.). | Quarterly | 13 |
| Pharmacy Management: Summary of Pharmacy Costs | The MCO shall report on pharmacy costs, including but not limited to:<br>• Total pharmacy claims and dollars paid, voided/reversed, denied,<br>• Number of members accessing pharmacy services, by member characteristics such as age, eligibility group, gender, etc.,<br>• Average, median and range of the number of prescriptions per user, | Quarterly | 13 |

| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | • Average, median and range of prescription claims and net cost in dollars per user, and by member characteristics such as age, eligibility group, gender, etc.,<br>• Drugs subject to a maximum allowable cost (MAC), the cost avoidance of MAC application,<br>• Co-payment required/not required, collected/not collected,<br>• Over the counter drug use by various parameters. | | |
| Pharmacy Management: Quality Improvement Initiatives | The MCO shall report on MCO Pharmacy Quality Improvement initiatives, including at minimum:<br>• Polypharmacy for physical and behavioral health medications,<br>• Maintenance medication adherence to eliminate gaps in refills,<br>• Use and reimbursement of child psychiatric consultation for behavioral health medications in children, and<br>• Other MCO initiated programs.<br><br>For each initiative, the MCO must provide objective outcomes and at the end of each Agreement year, a sufficient detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities. | Annually for Assessment, Quarterly Reporting on Pharmacy Quality Improvement progress | 13.1.10 |
| Pharmacy Management: Rebate Billing Support | The MCO shall provide pharmacy data file transfers to support all DHHS rebate billings and report on the:<br>• Date of file delivery,<br>• Accuracy and completeness of the file transferred, any absent date elements, the reason for the absence data, and the date the data will be provided,<br>• Any additional information or corrective actions needed to comprehensively support DHHS rebate filing. | Weekly | 13.1.11; 13.1.12 |
| Pharmacy Management: Third Party Liability Recoveries | The MCO shall report on any pharmacy costs billed to other payers or recovered from other payers, including, but not limited to:<br>• The name of the member,<br>• The name of the drug,<br>• Dispensing date,<br>• Amount allowed,<br>• Amount due from TPL<br>• Amount recovered. | Quarterly | 13.1.12 |
| Pharmacy Management: Lock-In | The MCO shall report on any programs with pharmacy or medication related restrictions, including, but not limited to:<br>• Number of members locked-in to a | Monthly | 24.1.22; 24.1.25 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | pharmacy, prescribers, or both,<br>• For each member locked in: the drug(s), prescribers(s) or pharmacy restriction, the lock-in date span, the reason/criterion met for the restriction, the date of last and the date of next review. | | |
| Member Enrollment and Disenrollment | The MCO shall report on:<br>• New members enrolled and the reason for each new enrollment,<br>• Members re-enrolled after a loss of Medicaid eligibility,<br>• Members disenrolled and the reason for each disenrollment, and<br>• Total members enrolled. | Monthly | 14 |
| Member Services: Member Communications | The MCO shall report on:<br>• Number of new member welcome calls, including, but not limited to the total number of calls made, the number of successful calls, the number of unsuccessful attempts,<br>• Number of initial enrollment letters and member handbooks mailed and received back as undeliverable,<br>• MCO member website with additional information on website use including, but not limited to, Number of hits to the website, time spent on the website, document downloads, requests for additional information, email use – number, proportion of contacts via email and reasons for email, email response statistics, maintenance and update events<br>• Inbound member call center utilization, (e.g. calls received, reason for the call, speed to answer, hold times, total call time, calls abandoned, voice messages left during and after business hours, etc.),<br>• Transferred member calls including, but not limited to the number of warm transfers, the program transferred to, any follow undertaken, etc.,<br>• After hours voice mail follow up, including, but not limited to the number and reason for the after hours calls, the date and time of the call, and the date and time of the returned calls by the next business day, | Monthly | 15.1.3; 15.1.4; 15.1.12; 15.4.5. 22.5.11 |
| Member Services: Member Engagement | The MCO shall report on member engagement through the Consumer Advisory Board (CAB) and Regional member meetings including, but not limited to,<br>• CAB member composition, or<br>• The number of members attending regional meetings, and | Annually | 15.7; 20.1.1 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | • Meeting times and locations,<br>• Agendas,<br>• MCO program impact attributable to the CAB and/or regional meetings. | | |
| Member Services: Member Satisfaction Survey | The MCO shall conduct and submit the results from an annual CAHPS survey with all available CAHPS measures and sections, including, but not limited to supplements, children with chronic conditions, and mobility impairment. | Annually | 15.7.3; 20.5 |
| Cultural Considerations: Race, Ethnicity and Primary Language | The MCO shall report on the following activities related to the culturally appropriate delivery of services:<br>• Member race, ethnicity and primary spoken and written language of its members,<br>• Community demographic, cultural and epidemiologic profile to address the cultural and linguistic characteristics of each of the MCO's services areas,<br>• Utilization of interpreter services for health plan service and medical services provided by its provider network, including, but not limited to the number of interpreters used and the number declined,<br>• Activities undertaken as a part of the MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by the service area community assessment. | Annually | 16.1.5; 16.1.7; 16.1.13.8; 16.1.13.11 |
| Grievance and Appeals: | The MCO shall report on all actions, grievances, and appeals, including, but not limited to all matters handled by delegated entities including but not limited to:<br>• Number of grievances, categories of grievance, member or provider characteristics grieving, any corrective action or response to the grievance (e.g. quality improvement project, operations changes, etc.), the date of filing and date of MCO response, (Quarterly),<br>• Grievances alleging discrimination related to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability (three days of MCO receipt),<br>• Number of and types of appeals (e.g. routine, expedited), the service/decision being appealed, characteristics of the appealing member, the MCO action, any corrective action or response to the appeal (e.g. quality improvement project, operations changes, etc.), the date filed and date of MCO, | Quarterly, Three (3) business days | 17.1.9; 26.2.2.4 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | response including, but not limited to any requested extensions and the reason for the extension, whether benefit continuation was required during the appeals timeframe, whether an upheld denial or partial denial continued to Fair Hearing with the date and decision from the Fair Hearing, (Quarterly). | | |
| Access: Provider Network Adequacy | The MCO shall report on the adequacy of its provider network including but not limited to:<br>• An assessment of the member demographics and anticipated medical services need including, but not limited to a community level assessment of services available and community level barriers to medical services,<br>• Provider access anticipated needs, including, but not limited to number, mix and geographic distribution to meet anticipated member needs,<br>• Provider participation report: provider participation reports by geographic location, categories of service, provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze provider service capacity in terms of realized member access to health care,<br>• Any MCO provider network exceptions requested and the DHHS response,<br>• Timely access to service delivery NH Medicaid Care Management contract standards for transition care after hospital or institutional discharge; preventive, routine, urgent and emergent care;<br>• Data to support access to a choice of primary care provides, and access to women's health, family planning and special services,<br>• Data to support accessibility to providers for members with disabilities,<br>• Description of the number and type of services provided out of network,<br>• Any corrective actions needed restore provider network adequacy to meet federal and state standards. | Quarterly | 18; 18.1.2; 18.2; 19.1.1; 22.5.18; 22.5.19 |
| Access: Provider Network Adequacy | The MCO shall report on Monitoring Access to Care in New Hampshire's Medicaid Program: MCO Access, to include all of the metrics measured and trended in the State's access reporting to CMS, including but not limited to:<br>• Quarterly enrollment by age, aid categories, metropolitan/non-metropolitan counties; | Quarterly, Annually | |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | • Primary care providers/pediatricians/OB-Gyn, member to provider ratios;<br>• Numbers of visits, total visits/1000 members, seasonally adjusted, by aid categories and by metropolitan/non-metropolitan counties;<br>• Emergency department utilization, total visits/1000 members, by aid categories, seasonally adjusted and by metropolitan/non-metropolitan counties;<br>• Inpatient utilization, total admissions/1000 members, by aid categories, seasonally adjusted and by metropolitan/non-metropolitan counties;<br>• Ambulatory sensitive condition admissions, total admissions/1000 members, seasonally adjusted;<br>• Well-Child, Adolescent, adult preventive or other ambulatory services, total visits/1000 members, by metropolitan/non-metropolitan counties;<br>• Member requests for assistance accessing providers, total requests/1000 members, by metropolitan/non-metropolitan counties. | | |
| Network Management: Network Overview | The MCO shall report an overview of its provider network for inclusion into the provider directory, the MCO website, to DHHS, to include but not be limited to for each provider:<br>• Provider type (hospital, pharmacy, physician, lab, etc),<br>• Provider Name,<br>• Practice Name,<br>• Specialty,<br>• Board Certification, Medicare certification, CLIA certification, JCAHO accreditation, etc as appropriate for the provider type,<br>• Address, telephone, ADA compliant, website,<br>• Hours of operation (e.g. Office hours including, but not limited to after hours, 24 hours pharmacy, etc.),<br>• Service limitations (e.g. specialty pharmacy only, DME – oxygen supplier only, etc).<br><br>The MCO shall report an overview of its provider network including but not limited to aggregate information on the data elements list above and including, but not limited to, the following data elements:<br>• Number of providers terminated and number | Annually | 18.2; 19.2.16; 19.2.18; 22.5.19 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | of providers newly enrolled by specialty, location, number of members affected,<br>• Geographic location of providers (by provider type) and members,<br>• Any transition plans needed to address any significant changes in the provider network,<br>• Provider Quality Report Card: provider dashboard or "report card" reports of provider service quality including but not limited to provider sanctions, timely fulfillment of service authorizations, count of service authorizations, etc. | | |
| Network Management: Provider Communications | The MCO shall report on:<br>• Provider training, including, but not limited to the date and location, subject of the training, number in attendance, training evaluation, and include in this report presentation the Behavioral Health: Mental Health Service Providers Training Reporting,<br>• Provider relations strategy, including, but not limited to the provider relations staff information, provider relations activates, and the impact of those activities,<br>• Inbound provider call utilization, (e.g. inbound calls received, reason for the call, speed to answer, hold times, total call time, calls abandoned, voice messages left during and after business hours, etc.),<br>• After hours voice mail follow up, including, but not limited to the number and reason for the after hours calls, the date and time of the call, and the date and time of the returned calls by the next business day,<br>• Number of hits on the MCO provider website with additional information on website use including, but not limited to but not limited to the number and proportion of utilization controls managed through the website, e-prescribing, document downloads, requests for additional information, email use – number, proportion of contacts via email and reasons for email, email response statistics, maintenance and update events. | | 12.1.10; 19.2.13; 19.2.15; 19.4.1; 22.5.11 |
| Network Management: Provider Engagement | The MCO shall report on provider engagement through the Provider Advisory Board (PAB) meetings including, but not limited to,<br>• PAB member composition,<br>• Meeting times and locations,<br>• Agendas,<br>• MCO program impact attributable to the PAB. | Annually | 19.4.1; 20.1.1 |
| Network | The MCO shall conduct and submit to DHHS the | Annually | 19.4.2 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| Management: Provider Satisfaction Survey | results from an annual provider satisfaction survey, approved by DHHS and administered by a third party. | | |
| Quality: QAPI Program Summary | The MCO shall have a Quality Assessment and Performance Improvement (QAPI) program summary including, but not limited to:<br>• Annual objectives and goals,<br>• Outcome measures to the greatest extent possible in addition to structure and process measures,<br>• Quantitative assessments to the greatest extent possible in addition to any qualitative assessments,<br>• Incorporate appropriate comparators which must be approved by DHHS prior to use,<br>• Sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities,<br>• Under and/or over-utilization,<br>• An assessment of the quality and appropriateness of care for members with special needs. | Annually, Quarterly | 20.1.7; 20.1.13; 20.4 |
| Quality: Performance Improvement Projects | The MCO shall conduct a minimum of four (4) performance improvement projects (PIP) each Agreement year that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. At least one of these projects shall have a behavioral health focus. The MCO shall report the status and results including but not limited to:<br>• Brief description of each PIP, PIP goals and progress toward each goal,<br>• Sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities. | Quarterly | 20.1.11 |
| Quality: Quality Measures | The MCO shall at minimum report on the following quality measure sets, including any additions made to these data set and any additional quality measures specified by DHHS:<br>• CMS CHIPRA Child Quality Measures,<br>• CMS Adult Quality Measures,<br>• NCQA Medicaid Accreditation HEDIS/CAHPS Measures, including all available CAHPS measures and sections, including supplements, children with chronic conditions, and mobility impairment,<br>• The measure contained in NH Medicaid Care | Annually | 20.5.1 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | Management Contract Exhibit O. | | |
| Quality: Performance Incentives | The MCO shall report the status and results of each annual Quality Incentive Program (QIP) initiatives including but not limited to:<br>• Brief description of each QIP, QIP goals and progress toward each goal<br>• Sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities. | Quarterly | 20.6 |
| Utilization Management: Service Utilization and Controls | The MCO shall report on services utilization and controls including but not limited to:<br>• Prior authorizations, number requested, service requested (e.g. DME, hospitalization, service limit override, etc) approved, denied, partially approved,<br>• Utilization controls decision making time frames for routine, urgent, continuation/extended, post service delivery<br>• Sites and types of services, (e.g. acute hospital, home health, transplants, readmissions, high risk obstetric cases, etc.) by total number and normalized (e.g. number of services/ x members, number of services / PMPM),<br>• Service utilization by various parameters (e.g. members eligibility group, member age, service provider, geographic site, etc.),<br>• Rankings and trends by various parameters (e.g. utilization counts, payment amounts, average payments, etc.),<br>• Annual reporting shall include, but not be limited to, an assessment of the impact of utilization controls on member, provide and program quality and costs; any unintended consequences; an assessment of any under-utilization and/or over-utilization; opportunities for improvement; impact of member and/or providers on changes to utilization controls. | Quarterly, Annually | 20.1.5; 21; 21.3 |
| MCIS: Data Transmissions from DHHS to MCO | DHHS shall provide a data transmissions to the MCOs to include:<br>• Provider extract (every two weeks),<br>• Recipient eligibility (daily),<br>• Recipient refresh data extract (every two weeks),<br>• Capitation payment data (monthly),<br>• Third party coverage (daily). | See specific transmission adjacent | 22.5.8; 25.1.1 |
| MCIS: Data Transmissions from the MCOs to DHHS | The MCO Managed Care Information System (MCIS) shall provide a data file to DHHS to include:<br>• Member benefit plan enrollment data (daily), | See specific transmission adjacent | 22.5.9; 23.2.21; 25.1.5 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | • Member encounter data including, but not limited to paid, denied, adjustment transactions by pay period (weekly/monthly),<br>• Member supplement including, but not limited to primary care provider assigned and group affiliation (weekly/monthly),<br>• Financial transaction data (weekly/monthly),<br>• Third party coverage data (monthly),<br>• Provider network file (monthly),<br>• Coordination of benefits data (monthly). | | |
| MCIS: Maintenance of Critical Systems | The following contingency plans shall be developed and tested to ensure continuous operation of the MCIS:<br>• Disaster recovery plan,<br>• Business continuity plan,<br>• Data Security plan including preventive, detective, corrective controls and HIPPA compliance),<br>• Joint interface plan,<br>• Risk management plan,<br>• Confirmation of 5010 compliance and companion guide,<br>• Confirmation of IRS publication 1075,<br>• ICD-10 implementation and compliance plan. | Annually and after any modification | 22.5.12.5; 22.5.12.6; 22.5.17.2 |
| MCIS: Encounter Data Quality | The MCO shall provide complete and accurate encounter data to DHHS. The MCO shall implement review procedures to validate encounter data submitted by providers. The MCO shall meet the following standards:<br>• Completeness: 99%,<br>• Accuracy: 98-100%,<br>• Timeliness: 100%,<br>• Error resolution: 100% (15 days). | See specific transmission adjacent | 23.2.24 |
| Fraud, Waste and Abuse: Comprehensive | The MCO shall report fraud, waste and abuse (FWA) information to DHHS including but not limited to,<br>• All audits, in progress and complete,<br>• Number of complaints of FWA warranting investigation including, but not limited to provider name and specialty, NPI, complaint source and nature, dollar amount,<br>• All FWA related to providers, including all communications regarding FWA, number of records requested, providers audited,<br>• Claims targeted for review and recovery, including claims analysis,<br>• Appeals, hearings related to FWA,<br>• Amounts recovered/owed,<br>• Provider training or corrective action to mitigate future FWA,<br>• Recommendations for to mitigate FWA | Annually, Quarterly | 24; 24.1.4; 24.1.12; 24.1.13; 24.1.15; 24.1.19; 24.1.26 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| | (annual report) including, but not limited to lock-in for medical services. | | |
| Third Party Liability: Cost Avoidance | The MCO shall report the number of claims cost avoided by the MCO's claims system, including, but not limited to the amount of funds, the amounts billed, the amounts not collected, and the amounts denied. | Monthly | 25; 25.1.2; 25.1.3; 25.1.5 |
| Third Party Liability: Accident and Trauma | The MCO shall provide DHHS with a report including but not limited to:<br>• Detailed claim for accident and trauma cases,<br>• Accident questionnaire,<br>• MCO intent to pursue and recover. | Monthly | 25.1.4; 25.4.2; 25.4.4 |
| Administrative Quality Assurance Standards | The MCO shall routinely measure the accuracy of claims processing and report results to DHHS including but not limited to:<br>• Adjudication of claims: 95% of clean claims within thirty (30) days of receipt, 100% of all claims within sixty (60) days, and any interest paid on claims > 30 days,<br>• Financial accuracy: 99%,<br>• Payment accuracy: 97%,<br>• Claims accuracy: 95%,<br>• A review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims,<br>• Corrective action plans needed to address claims payment accuracy issues. | Monthly | 27; 27.1.1; 27.2.1; 27.3; 27.4; 27.5 |
| Privacy and Security of Members | The MCO shall report any suspicion of any violation of personal health information with one (1) day of receipt of any information suggesting any violation to DHHS. | One (1) day | 28 |
| Finance: MCO Audits | The MCO shall provide DHHS a copy of its audited financial statements. | Annually | 29.7 |
| Termination Plan | MCO must prepare a Transition Plan that is acceptable to and approved by DHHS to be implemented between receipt of notice and the termination date. | Care Management program start | 30.1.1 |
| **Additional Reports Anticipated in Step 2** | | | |
| Behavioral Health: Consumer Assessment of Health and Satisfaction | NH Public Mental Health Consumer Survey, Data Infrastructure Grant Mental Health Consumer Survey or Mental Health Sickness Indicator Profile (MHSIP) Consumer Survey | Annually | Step 2 |
| Developmental Services: Consumer and Family Assessment of Health and Satisfaction | National Care Indicators Adult Consumer, Adult Family, Family Guardian, and Child Family Surveys. | Biennially | Step 2 |
| Elderly and Adult Services: Experience | CMS Participant Experience Survey | Annually | Step 2 |

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| Program and Report Name | Brief Description | Frequency | MCO Contract Reference (Section) |
|---|---|---|---|
| of Care | | | |

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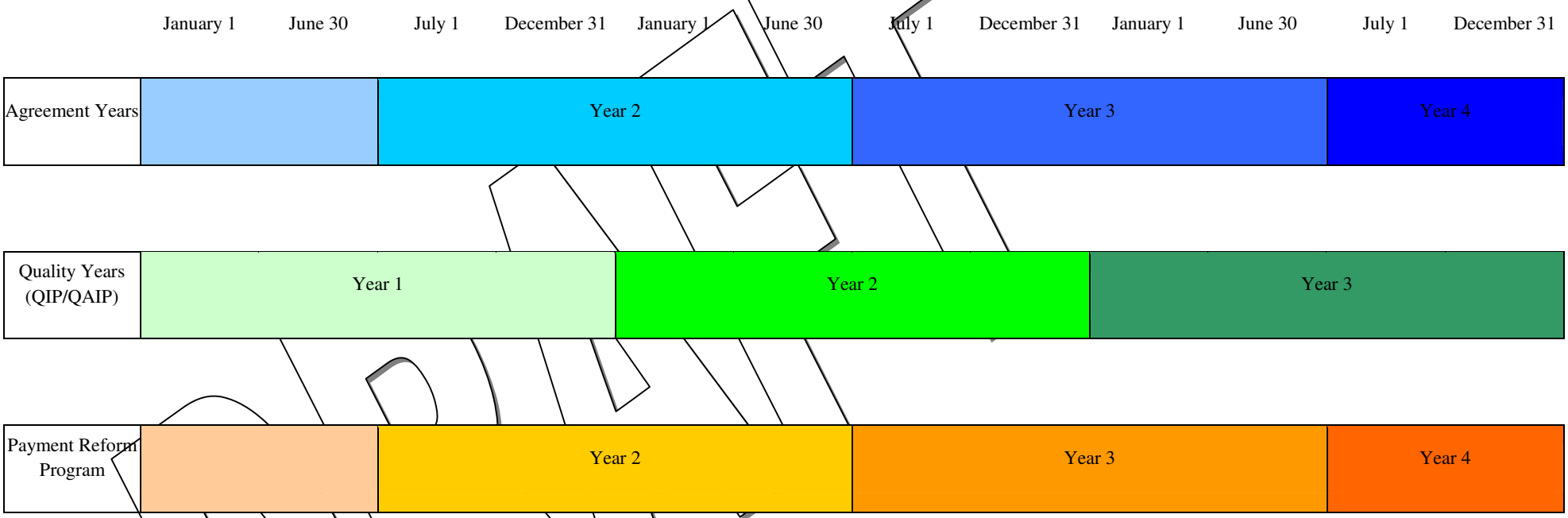
**Appendix H: NH Medicaid Care Management Program Timelines**

*Last Updated 7.12.12. Consult with the Department for any recent updates prior to use.*

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## Appendix I: Abbreviations and Acronyms

| | |
|---|---|
| AHRQ | Agency for Healthcare Research and Quality |
| BRFSS | Behavioral Risk Factor Surveillance System |
| CAHPS | Consumer Assessment of Health Providers and Systems |
| CDC | Center for Disease Control and Prevention |
| CFR | Code of Federal Regulations |
| CHIS | Comprehensive Health Care Information System |
| CMS | Center for Medicare and Medicaid Services |
| DHHS | Department of Health and Human Services |
| EQRO | External Quality Review Organization |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HER | Electronic Health Record |
| HIE | Health Information Exchange |
| HITECH | Health Information Technology for Economic and Clinical Health |
| MCO | Managed Care Organization |
| MMIS | Medicaid Mangagement Information System |
| NCQA | National Committee for Quality Assurance |
| NH | New Hampshire |
| PIP | Performance Improvement Program |
| QAPI | Quality Assurance Performance Improvement |
| QIP | Quality Incentive Project |
| SAMHSA | Substance Abuse and Mental Health Services Administration |

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